**U.S. Department of Health and Human Services**
**Office of the Assistant Secretary for Preparedness and Response**
**Hospital Preparedness Program (HPP)**

**Funding Opportunity Announcement (FOA)**
**and Grant Application Instructions**
**Funding Opportunity Title:**

**Hospital Preparedness Program Cooperative Agreement**

(CFDA # 93.889)

**Funding Opportunity Number:** EP-U3R-19-001

**All applications must be submitted by:** May 3, 2019

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# I. FUNDING OPPORTUNITY DESCRIPTION

## A. Executive Summary and Background

The U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) leads the country in preparing for, responding to, and recovering from the adverse health effects of emergencies and disasters. ASPR's programs improve the nation's ability to withstand adversity, strengthen health and emergency response systems, and enhance national health security. ASPR's Hospital Preparedness Program (HPP) is the only source of federal funding specifically for health care delivery system readiness. HPP aims to improve patient outcomes, minimize the need for federal and supplemental state resources during emergencies, and enable rapid recovery from catastrophic events through the development of health care coalitions (HCCs). HCCs incentivize and support diverse and often competitive health care organizations with differing priorities and objectives to work together to save lives during disasters and emergencies that exceed the day-to-day capacity and capability of individual health care and emergency response systems. ASPR recognizes that there is shared authority and accountability for the health care delivery system's readiness that rests with private organizations, government agencies, and states'/jurisdictions' Emergency Support Function 8 (ESF-8) – Public Health and Medical Services lead agencies. HCCs serve an important communication and coordination role within their jurisdictions, given the many public and private entities that must come together to ensure health care delivery system readiness.

To describe what health care delivery system partners, including HCCs, health care organizations, and emergency medical services (EMS), must do to effectively prepare for and respond to emergencies ASPR developed the [2017-2022 Health Care Preparedness and Response Capabilities](#). These capabilities illustrate the range of health care preparedness and response activities that, if conducted, represent the ideal state of readiness in the United States. Individual health care organizations, HCCs, jurisdictions, and other stakeholders that develop the capabilities outlined in the [2017-2022 Health Care Preparedness and Response Capabilities](#) document will help patients receive the care they need at the right place, at the right time, and with the right resources during emergencies; decrease deaths, injuries, and illnesses resulting from emergencies; and promote health care delivery system resilience in the aftermath of emergencies.

The goals of the four health care preparedness and response capabilities are as follows:

### Capability 1: Foundation for Health Care and Medical Readiness

The community's health care organizations and other stakeholders – coordinated through a sustainable HCC – have strong relationships, identify hazards and risks, and prioritize and address gaps through planning, training, exercising, and managing resources.

### Capability 2: Health Care and Medical Response Coordination

Health care organizations, the HCC, their jurisdiction(s), and the state's/jurisdiction's ESF-8 lead agency plan and collaborate to share and analyze information, manage and share resources, and coordinate strategies to deliver medical care to all populations during emergencies and planned events.

### Capability 3: Continuity of Health Care Service Delivery

Health care organizations, with support from the HCC and the state's/jurisdiction's ESF-8 lead agency, provide uninterrupted, optimal medical care to all populations in the face of damaged or disabled health care infrastructure. Health care workers are well-trained, well-educated, and well-equipped to care for patients during emergencies. Simultaneous response and recovery operations result in a return to normal or, ideally, improved operations.

**Capability 4: Medical Surge**

Health care organizations deliver timely and efficient care to their patients even when the demand for health care services exceeds available supply. The HCC, in collaboration with the state's/jurisdiction's ESF-8 lead agency, coordinates information and available resources for its members to maintain conventional surge response. When an emergency overwhelms the HCC's collective resources, the HCC supports the health care delivery system's transition to contingency and crisis surge response and promotes a timely return to conventional standards of care as soon as possible.

ASPR recognizes that the entirety of the [2017-2022 Health Care Preparedness and Response Capabilities](#) will not be achieved solely with the funding provided to HPP recipients and sub-recipients (including HCCs and health care organizations) through the HPP cooperative agreement. This FOA describes ASPR's expectations and priorities and lists performance measures for assessing HPP recipients' and sub-recipients' progress toward building the capabilities. **Overall, the goal of the HPP cooperative agreement is to build acute care medical surge capacity through the maintenance and growth of strong HCCs.**

## B. Statutory Authorities

**Overarching Authorities**

Section 319C-2 of the Public Health Service (PHS) Act (title 42 United States Code (USC) § 247d-3b), as amended.

Section 311 of the PHS Act (title 42 USC § 243), subject to available funding and other requirements and limitations.

### 1. References

The following are federal strategies, guidance documents, and directives that support the authorities and objectives of the readiness and response activities detailed in this FOA.

- [2017-2022 Health Care Preparedness and Response Capabilities](#)
- 2019 HPP Performance Measures Implementation Guidance (to be released in Spring 2019)
- [Healthy People 2020](#)
    - [Preparedness objectives for Healthy People 2020](#)
- [HHS Pandemic Influenza Plan](#)
- [Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health](#)
- [Homeland Security Presidential Directive (HSPD)-5 (Management of Domestic Incidents)](#)
- [HSPD-21 (Public Health and Medical Preparedness)](#)
- [Presidential Policy Directive-8 (National Preparedness)](#)
- [National Health Security Strategy](#)
- [Centers for Medicare and Medicaid Services (CMS); Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers (Rule CMS-3178-F)](#)
- [Homeland Security Exercise and Evaluation Program (HSEEP)](#)
- [International Health Regulation Monitoring and Evaluation Framework](#)

- [National Incident Management System (NIMS)](#)
- [National Preparedness Goal](#)

## C. Purpose

The purpose of this FOA is to strengthen and enhance the acute care medical surge capacity through the maintenance and growth of strong HCCs within each HPP-funded state, territory, freely associated state, and locality. This FOA provides funds to build acute care medical surge capacity by ensuring that HPP recipients focus on objectives and activities that advance progress toward meeting the goals of the four capabilities detailed in the [2017-2022 Health Care Preparedness and Response Capabilities](#) and document progress in establishing or maintaining response-ready health care systems through strong HCCs.

## D. Implementation

### Health Care Preparedness and Response Capabilities

Throughout the project period, ASPR expects recipients and sub-recipients to develop and strengthen the four health care preparedness and response capabilities through the implementation of *select* objectives and activities. ASPR has prioritized these select objectives and activities, recognizing that not all of the objectives and activities listed in the [2017-2022 Health Care Preparedness and Response Capabilities](#) can be implemented with the funding available through HPP.

ASPR encourages HCCs, health care organizations, and other stakeholders supporting the provision of care during emergencies to use [ASPR's Technical Resources, Assistance Center, and Information Exchange (TRACIE)](#) to receive assistance and resources for developing the capabilities.

### Readiness and Operations Cycle

HPP's readiness and operations cycle furthers the concepts outlined in the [National Preparedness Goal](#) by organizing the objectives and activities of the [2017-2022 Health Care Preparedness and Response Capabilities](#) into phases. The phases of the annual readiness and operations cycle strengthen HPP's focus on readying our health care systems for response to medical surge emergencies.

### HPP FOA Structure

Recipients and HCCs will structure their work plans by the [2017-2022 Health Care Preparedness and Response Capabilities](#). Within each capability, work plan activities will progress each year through the readiness and operations cycle (See HPP FOA Structure in Figure 1).

**Figure 1. HPP FOA Structure**

Ideally, work plan activities under each phase will correspond to quarters in each fiscal year (FY). In quarter one, activities would focus on planning and preparing. In quarter two, activities would focus on training and equipping. In quarter three, activities would focus on exercising, and in quarter four, activities would focus on evaluating and sharing lessons learned. While responses are the optimal tests of plans and training activities, these naturally occur at any point in the cycle—when disasters strike—and should be followed by the evaluation, planning, and training phases based on lessons learned from each response.

Utilization of the readiness and operations cycle will support recipients and sub-recipients in making continuous improvements each year.

**Please refer to Appendix A for explicit guidance on objectives and activities required for this project period.** This appendix includes all HPP-specific requirements and joint activities with the Centers for Disease Control and Prevention (CDC) Public Health Emergency Preparedness (PHEP) program, as well as other requirements associated with statute and HHS grant guidance.

**Option for Flexibility for Remote and Isolated Frontier Communities**

For the FY 2019-2023 project period, HPP recognizes the unique challenges and needs of hospitals located in remote and isolated frontier communities. To improve the effectiveness of HPP funding and to reduce the burden on recipients and sub-recipients, ASPR worked with the Health Resources and Services Administration (HRSA) Office of Rural Health Policy to categorize these hospitals and offer modified objectives, activities, and funding requirements. To be eligible for classification as an "isolated frontier hospital", hospitals must meet the following criteria:

- Be located in a geographic region within the U.S. that is classified by the U.S. Department of Agriculture Economic Research Service as both Frontier and Remote Area (FAR) level 4 (see Appendix B), *and*

- Be greater than 60 miles from the next nearest hospital. It is the responsibility of the recipient to determine if a hospital located in a FAR level 4 locale is greater than 60 miles from the next nearest hospital.

ASPR will consider requests for facility classification as an "isolated frontier hospital" on a case-by-case basis. Each recipient must submit requests for classification during the application process (in Grants.gov , reference Section IV.C.Additional information for upload instructions) in the format of a letter to the HPP Director (please see contact information at the end of this announcement). HPP will not accept post-

award classification requests. The letter should contain the full legal name of the identified hospital, its current physical address, the name and distance (in miles) to the next nearest hospital, and a justification explaining how this classification will improve the readiness of both the facility and HCC. Each recipient should include an accompanying letter of support from the current HCC, which must indicate the HCC understands the impact of this classification and supports the request to modify the existing activities and funding strategies for the identified hospital(s). Additional letters of support from the jurisdiction's hospital association will further strengthen requests for classification.

The HPP-specific requirements and HPP-PHEP joint activities found in Appendix A apply to all recipients including territories, freely associated states, and isolated frontier hospitals (as defined above). However, additional guidance and technical assistance (TA) that describe modified requirements for ASPR-approved "isolated frontier hospitals" as well as American Samoa (AS), the Commonwealth of the Northern Mariana Islands (CNMI), Guam, the U.S. Virgin Islands (USVI), the freely associated states including the Federated States of Micronesia (FSM), the Republic of the Marshall Islands (RMI), and the Republic of Palau (PW) can be found in Appendix C.

**Federal Requirements**

For the FY 2019-2023 project period, recipients must address and comply with other federal requirements that include HPP-specific requirements and HPP-PHEP joint activities and assurances. In completing the program requirements segment of the funding application, recipients must provide updates on the following programmatic requirements and assurances:

1. **Coordinate exercise planning and implementation.**

   - Recipients must conduct an annual public health and medical preparedness exercise that specifically addresses the needs of people with disabilities and other at-risk individuals or populations and report in the following year's funding application on the strengths and weaknesses identified and corrective actions taken to address weaknesses. HPP recipients should consider the access and functional needs of at-risk individuals and engage these populations as they plan the budget period's HCC-based exercises.

   - Recipients must complete and submit after action reports and improvement plans (AAR/IPs) for all responses to real incidents and planned events and for exercises conducted to demonstrate compliance with HPP program requirements. HPP recipients should provide AAR/IPs to ASPR in accordance with HSEEP guidelines for each qualifying exercise within 120 days.

2. **Submit pandemic influenza preparedness plans.**

   - HPP's authorization (sections 319C-1 and 319C-2 of the PHS Act) requires recipients to have updated plans describing activities they will conduct with respect to pandemic influenza.

   - HPP recipients can satisfy the annual requirement through the submission of required program data such as the capability self-assessment and program measures that provide information on the status of state and local pandemic response readiness, barriers and challenges to preparedness and operational readiness, and efforts to address the needs of at-risk individuals.

3. **Describe progress on capability development.**

   - Recipients must describe the top jurisdictional strategic priorities for the project period.

   - Recipients must identify the data sources used to inform the strategic priorities. Sources

include but are not limited to jurisdictional risk assessments, capability self-assessments, National Health Security Preparedness Index (NHSPI), and AAR/IPs.

- Recipients must list challenges or barriers that are anticipated for the project period, including any budgetary issues that might hinder the success or completion of the project as originally proposed and approved.

4. **Establish and maintain senior advisory committees.**

- Recipients must establish and maintain advisory committees or similar mechanisms of senior officials from governmental and non-governmental organizations involved in homeland security, health care, public health, EMS, and behavioral health to help integrate preparedness efforts across jurisdictions and to maximize funding streams.

5. **Coordinate emergency public health and health care preparedness and response plans with educational agencies and state child care agencies.**

- Recipients must ensure emergency preparedness and response coordination with educational agencies and child care agencies in their jurisdictions.

6. **Engage State Unit on Aging or the equivalent office.**

- Recipients must engage the State Unit on Aging, Area Agency on Aging, or an equivalent office in addressing the public health emergency preparedness, response, and recovery needs of older adults. Recipients must provide evidence that this state office is engaged in the jurisdictional planning process.

7. **Meet Emergency System for Advance Registration of Volunteer Health Professionals (ESAR- VHP) compliance requirements.**

- The ESAR-VHP compliance requirements identify capabilities and procedures that state ESAR-VHP programs must have in place to ensure effective management and inter-jurisdictional movement of volunteer health personnel in emergencies. Recipients must coordinate with volunteer health professional entities. ASPR also encourages recipients to collaborate with the Medical Reserve Corps (MRC) to facilitate the integration of MRC units with the local, state, and regional infrastructure to help ensure an efficient response to a public health emergency. More information about the MRC program can be found on the MRC webpage.

8. **Ensure cross-discipline coordination.**

- Recipients may use HPP funding to support coordination activities, such as planning activities between local health departments and HCCs, but must track the accomplishments and outcomes of these activities. Recipients should coordinate activities with state emergency management agencies, EMS providers (including the State Office of Emergency Medical Services), mental health agencies (including the State Mental Health Authority and the Disaster Behavioral Health Coordinator), HCCs, state aging offices, and educational agencies, state child care agencies, MRC, and ESAR-VHP programs.

9. **Comply with SAFECOM requirements.**

- Recipients and sub-recipients that use federal preparedness grant funds to support emergency communications activities must comply with current SAFECOM guidance for emergency communications grants, which is available on the SAFECOM webpage.

10. **Cooperative agreement administrative requirements.**

- Recipients must submit required progress reports and program and financial data by the deadline, including budgets and work plans; progress in achieving evidence-based benchmarks and objective standards; performance measures data, including data from local health departments; outcomes of annual preparedness exercises including strengths, weaknesses and associated corrective actions; and accomplishments highlighting the impact and value of the HPP activities in their jurisdictions.

  - In a cooperative agreement, the federal government is substantially involved in the program activities, above and beyond routine grant monitoring. During the project period, ASPR will monitor and evaluate the defined activities within the agreement and recipient progress in meeting work plan priorities. The recipient must ensure reasonable access by ASPR or their designees to all necessary sites, documentation, individuals and information to monitor, evaluate and verify the appropriate implementation the activities and use of ASPR funds under this agreement.

  - Recipients must have in place fiscal and programmatic systems to document accountability and improvement, and must demonstrate these systems during site visits.

    - Recipients must plan and participate in joint site visits at least once every 12-24 months.

    - ASPR encourages recipients to invite HPP field project officers (FPOs) and senior ASPR staff to attend or observe events such as scheduled exercises, regional meetings, jurisdictional conferences, senior advisory committee meetings, and coalition meetings supported by HPP funding.

  - Recipients must participate in mandatory meetings and trainings. ASPR considers the following meetings mandatory; recipients should budget travel funds accordingly:

    - Annual preparedness summit sponsored by the National Association of County and City Health Officials

    - Directors of Public Health Preparedness annual meeting sponsored by the Association of State and Territorial Health Officials

    - National Health Care Coalition Preparedness Conference, as specified by ASPR

    - Training for medical countermeasure (MCM) coordinators sponsored by ASPR and other MCM regional workshops

    - Other mandatory training sessions that may be conducted via webinar or other remote meeting venues

- Recipients must maintain all program documentation for purposes of data verification and validation. ASPR strongly encourages recipients to develop internal electronic systems that allow jurisdictions to share documentation with HPP FPOs, including evidence of progress completing corrective actions for weaknesses identified during exercises and drills. In FY 2019/budget period 1, ASPR will increase the emphasis on verification and validation of requirements to identify strengths and potential gaps, better review and evaluate progress, and provide TA.

- Recipients must engage in TA planning. Recipients must actively work with their HPP FPOs to properly identify, manage, assess progress of, and update TA plans at least

quarterly. ASPR encourages HCCs, health care organizations and other stakeholders supporting the provision of care during emergencies to use [ASPR's TRACIE](#) system to identify existing TA resources.

**Accountability Provisions**

Recipients that fail to "substantially meet" the benchmarks required by this FOA are subject to withholding of a statutorily mandated percentage of the award if a recipient fails substantially to meet established benchmarks for the immediately preceding fiscal year or fails to submit a satisfactory pandemic influenza plan.

HHS is required to treat each failure to substantially meet all the benchmarks and each failure to submit a satisfactory pandemic influenza plan as a separate withholding action. For example, a recipient failing substantially to meet benchmarks AND who fails to submit a satisfactory pandemic influenza plan could have 10 percent withheld for each failure for a total of 20 percent for the first year this happens. If this situation remains unchanged, HHS would then be required to assess 15 percent for each failure for a total of 30 percent for the second year this happens. Alternatively, if a recipient corrects one of the two failures in the second year but one remains, HHS is required to withhold 15 percent of the second-year funding.

**Table 1. FY 2019 Benchmarks**

| | Benchmark (BM) Description | Recipient | HCC | Possible % of Withholding |
|---|---|---|---|---|
| **HPP BENCHMARKS: All recipients** | | | | |
| BM1 | Recipients **must** execute subawards with each HCC within 90 calendar days from the start of each budget period. | X | | |
| BM2 | Recipients **must** submit quarterly Federal Financial Reports (FFRs) within 30 calendar days of Notice of Award deadlines during each budget period. | X | | |
| BM3 | Recipients **must** submit a joint multiyear training and exercise plan (MYTEP) with each budget period application package (uploaded into PERFORMS or other program management system, when available). | X | | |
| BM4 | HCCs **must** have a draft response plan annex addressing pediatric surge completed and uploaded by April 1, 2020. Final plans must be submitted with the FY 2019 Annual Progress Report (APR). | | X | 10% |
| BM5 | Within the first 60 days of each budget period, all recipients **must** provide a detailed spend plan, including all budget line items, to all HCCs within their jurisdiction and any interested health care entity. | X | | |
| BM6 | Within 30 days following receipt of the subaward, all funded HCCs **must** submit their final budgets to the recipients and uploaded a copy into the Coalition Assessment Tool (CAT). The budget should identify the percent of funding received from the recipient, other federal sources, and non-federal sources. | | X | |

| | Benchmark (BM) Description | Recipient | HCC | Possible % of Withholding |
|---|---|---|---|---|
| BM7 | Within 30 days following receipt of the subaward, all funded HCCs **must** submit an annual work plan (uploaded into the CAT), developed in collaboration with their stakeholders and based on their current hazard vulnerability analysis (HVA) and resource analysis, to include medical equipment and supplies, real-time information sharing, communication systems, training, exercises, lessons learned, and health care personnel necessary to respond to an emergency. In FYs 2020-2023, all funded HCCs **must** submit their draft annual workplan and budget to the recipient by January 31 for inclusion in the recipient's application. | X | X | |
| BM8 | Within the first 90 days of each budget period, all recipients and HCCs **must** provide ASPR an updated pre-event specific essential elements of information (EEI) template (uploaded into the CAT). ASPR will provide recipients with a list of all required post-event and special-event EEIs for incorporation into state, local, and HCC reporting systems. | X | X | |
| BM9 | HCCs **must** complete the Coalition Surge Test (CST) annually. Hospitals located in approved jurisdictions (AS, CNMI, FSM, PW, RMI, Guam and USVI) or officially classified as an isolated frontier hospital, **must** develop a surge scenario and exercise it annually utilizing the Hospital Surge Tool (HST), in lieu of the CST. Data **must** be uploaded into the CAT. | | X | |
| BM10 | All recipients **must** submit required program data such as the capability self-assessment and program measures that provide information on the status of state and local pandemic response readiness, barriers and challenges to preparedness and operational readiness, and efforts to address the needs of at-risk individuals. | X | | 10% |
| Total Potential Withholding Percentage | | | | 20% |

**Evaluation and Performance Measurement**

To measure and evaluate HPP performance, ASPR developed a variety of measures at the input-, activity,- output-, and outcome-level to address the information needs of various stakeholders. See Appendix D for a list of the FY 2019/budget period 1 HPP performance measures.

ASPR will update the 2017-2022 Hospital Preparedness Program Performance Measures Implementation Guidance in the spring of 2019 to incorporate minor changes to the performance measures for FY 2019/budget period 1.

ASPR will review and evaluate HPP recipients based on a number of sources of information including performance measure data, information gathered during site visits, produced AAR/IPs, and HCC response plans. ASPR will also use this information to identify program areas to be improved, program successes, and key areas of TA to provide to recipients and their HCCs. The HPP performance measures monitor implementation of the program, and are intended to help assess an HCC's readiness to respond in an emergency.

# E. ASPR Activities

**Field Project Officer**

FPOs serve as the federal liaisons to each designated HHS region and coordinate between HPP and its cooperative agreement recipients. FPOs provide TA on programmatic activities and grants, conduct recipient and HCC site visits, and monitor activity and project funds. Note that many requirements of this cooperative agreement request the submission of HCC documentation to the FPOs, importantly including data during an actual emergency response.

**ASPR TRACIE**

ASPR TRACIE provides information and TA to HCCs, providers, emergency managers, and others working in health care system preparedness and disaster medicine. It offers support in three main areas: a self-service collection of disaster medical, health care and public health materials searchable by keyword and functional area; one-on-one TA support to request documentation and resources; and a peer-to-peer closed forum where providers and responders can communicate in a timely way. For example, ASPR TRACIE can provide users with TA and resources to support specific capability development. ASPR encourages HCCs, health care organizations and other stakeholders supporting the provision of care during emergencies to use ASPR's TRACIE system.

**ASPR Grants Management Office**

The ASPR Grants Management Office is responsible for the business management aspects of HPP cooperative agreements, including review, negotiation, award, and administration. These activities include, but are not limited to, evaluating applications for administrative content and compliance with statutes, regulations, and guidelines; negotiating grants; providing consultation and TA to recipients; and administering grants after award.

**Health Care Coalition Response Leadership Course**

The Health Care Coalition Response Leadership Course sponsored by the Center for Domestic Preparedness in Anniston, Alabama, will be available to HCCs to provide guidance and training. The

Center for Domestic Preparedness will cover travel, lodging, and training costs. Recipients and HCCs do not need to budget for these travel and training costs.

**Evaluation and Monitoring of Program**

In a cooperative agreement, the federal government is substantially involved in the program activities, above and beyond routine grant monitoring. During the project period, ASPR will monitor and evaluate the defined activities within the agreement and recipient progress in meeting work plan priorities. The recipient must ensure reasonable access by ASPR or their designees to all necessary sites, documentation, individuals and information to monitor, evaluate, and verify the appropriate implementation the activities and use of ASPR funding under this agreement.

**Collaborations**

1. **HPP and PHEP**

   HPP and PHEP remain programmatically aligned and are proud to be the first aligned grant programs in the federal government. The programs were initially aligned in 2012 in order to better coordinate the private health care sector and state and local public health sector for improved preparedness and response. HPP and PHEP funds are not interchangeable, although funding flows through the same 62 state, local, and territorial recipients. HPP builds resilience among health care delivery system entities by increasing their collective ability to maintain operations and expand health care capacity during a medical surge. Primary sub-recipients are HCCs and individual health care facilities. The PHEP program builds capacity within state, local, territorial, and tribal public health agencies to assure that the nation's public health system is resilient and "response ready" for any type of public health event or disaster.

2. **HPP Partner Community**

   HPP continues to develop a partner community of external stakeholders to ensure an exchange of ideas and demonstrate mutual relationship value. These stakeholders include national trade associations representing health care providers and public health, foundations, academic institutions, and other non-profits whose missions align with HPP's preparedness, response, and recovery efforts.

3. **Emergency Medical Services for Children (EMSC)**

   HPP recipients and the Health Resources and Services Administration (HRSA) EMSC program recipients within their jurisdictions must provide a joint letter of support indicating that EMSC and HPP are linked at the recipient level. HPP recipients must provide a letter of support with their funding applications at the beginning of each budget period throughout the five-year project period.

   Please note: funding cannot be used for activities already covered by other federal grants or cooperative agreements.

4. **Emergency Preparedness Grant Coordination (EPGC)**

   Federal agencies participating in the EPGC process are working to identify current preparedness activities and areas for collaboration across federal grants with public health and health care preparedness components. The participating federal agencies include:

   - HHS ASPR
   - Department of Homeland Security (DHS) Federal Emergency Management Agency

(FEMA)

- HHS Centers for Disease Control and Prevention (CDC)

- HHS Health Resources and Services Administration (HRSA)

- Department of Transportation (DOT) National Highway Traffic Safety Administration (NHTSA)

Federal agencies are actively coordinating guidance and TA and encourage all recipients to actively coordinate preparedness activities for their jurisdictions.

More information on the EPGC process can be found on the EPGC webpage.

## F. Other Important Notes about this Funding Opportunity Announcement

**Target Populations**

This FOA targets, in broad terms, the entire U.S. population and the health care systems within the U.S. and its territories and freely associated states. Specifically, funds are intended to support the needs of any community impacted by a public health emergency or disaster and to ensure that health care systems are ready and capable of keeping their communities safe and mitigating the impacts of any public health emergency. There is a special emphasis on preparing for the health needs of at-risk populations, including tribal entities. Accommodations for at-risk populations should be incorporated into all plans and exercises and any access or functional needs of at-risk populations that may interfere with their ability to access or receive medical care before, during, or after a disaster or emergency should be considered.

**Health Disparities**

Recipients must show evidence that they are integrating accommodations for the access and functional needs of at-risk and vulnerable population(s) as indicated into their planning. Recipients must describe the structure or processes in place to integrate accommodations for the access and functional needs of at-risk individuals, including but not limited to children, pregnant women, older adults, people with disabilities, and people with limited English proficiency and non-English speaking populations. Strategies to integrate the access and functional needs of at-risk individuals involve inclusion in public health, health care, and behavioral health response strategies; furthermore, these strategies are identified and addressed in operational work plans. ASPR encourages recipients, sub-recipients, and HCCs to identify community partners with established relationships with diverse at-risk populations, such as social services organizations, and to use demographic tools such as the Social Vulnerability Index and the U.S. Census/American Community Survey to better anticipate the potential access and functional needs of at-risk community members before, during, and after an emergency. Applicants must also ensure inclusive planning with tribes.

## II. AWARD INFORMATION

**FOA Title:** Hospital Preparedness Program Cooperative Agreement

**Type of Award:** Cooperative agreement

**Fiscal Year Funds:** FY 2019-2023

**Approximate Total Funding:** $231,500,000 USD

This amount is subject to availability of funds. Includes direct and indirect costs.

**Approximate Number of Awards:** 62

**Approximate Average Award:** $3,733,871 USD

**Floor of Individual Award Range:** $256,518 USD

**Ceiling of Individual Award Range:** $23,274,780 USD

**Anticipated Award Date:** July 1, 2019

**Budget Period Length:** July 1, 2019 through June 30, 2020

**Project Period Length:** July 1, 2019 through June 30, 2024

# III. ELIGIBILITY INFORMATION

## A. Eligible Applicants

As defined in sections 319C-1 and 319C-2 of the PHS Act, eligible applicants for this funding opportunity are states, a consortium of states, or eligible political subdivisions that prepare and submit a sufficient application compliant with the statutory and administrative requirements described in this document. For the purposes of this announcement, the term "state" may include a state, territory, or freely associated state.

## B. Funding Strategy

ASPR calculates the distribution of HPP funds using a formula established under section 319C-1(h) of the PHS Act, as amended. States and U.S. territories and freely associated states receive the greater of a minimum amount prescribed by the formula or a base amount, as determined by the Secretary, supplemented by a population-based formula, and possible additional funding based on findings about significant unmet needs or high degree of risk. Eligible political subdivisions receive an amount determined by the Secretary and possible additional funding based on findings about significant unmet needs or high degree of risk.

## C. Cost Sharing and Match

ASPR may not award a cooperative agreement to a state or consortium of states under these programs unless the recipient agrees that, with respect to the amount of the cooperative agreements awarded by ASPR, the state will make available non-federal contributions in the amount of 10 percent ($1 for each $10 of federal funds provided in the cooperative agreement) of the award.

Match may be provided directly or through donations from public or private entities and may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the federal government or services assisted or subsidized to any significant extent by the federal government may not be included in determining the amount of such non-federal contributions.

Please refer to title 45 of the Code of Federal Regulations (CFR) § 75.306 for match requirements, including descriptions of acceptable match resources. Documentation of match, including methods and sources, must be included in the FY 2019/budget period 1 application for funds, follow procedures for generally accepted accounting practices, and meet audit requirements.

Exceptions to Matching Funds Requirement:

- The match requirement does not apply to the political subdivisions of Chicago, Los Angeles County, or New York City.

- Pursuant to department grants policy implementing 48 USC 1469a(d), any required matching

(including in-kind contributions) of less than $200,000 is waived with respect to cooperative agreements to the governments of AS, Guam, USVI, or CNMI (other than those consolidated under other provisions of 48 USC 1469). For instance, if 10 percent (the match requirement) of the award is less than $200,000, then the entire match requirement is waived. If 10 percent of the award is greater than $200,000, then the first $200,000 is waived, and the rest must be paid as match.

- The match requirement is also waived for the freely associated states, including PW, FSM, and RMI.

- Matching does not apply to future contingent emergency response awards that may be authorized under section 311 of the PHS Act unless such a requirement were imposed by statute or administrative process at the time.

## D. Maintenance of Effort

According to section 319C-2 of the PHS Act, recipients must maintain expenditures for health care preparedness at a level that is not less than the average level of such expenditures maintained by the recipient for the preceding two-year period. This represents a recipient's historical level of contributions or expenditures (money spent) related to federal programmatic activities that have been made prior to the receipt of federal funds. The maintenance of effort (MOE) is used as an indicator of non-federal support for health care preparedness before the infusion of federal funds. These expenditures are calculated by the recipient without reference to any federal funding that also may have contributed to such programmatic activities in the past. The definition of eligible state expenditures for health care preparedness includes:

- Appropriations specifically designed to support health care preparedness as expended by the entity receiving the award; and

- Funds not specifically appropriated for health care preparedness activities, but which support health care preparedness activities, such as personnel assigned to health care preparedness responsibilities, supplies, or equipment purchased for health care preparedness from general funds or other lines within the operating budget of the entity receiving the award.

Recipients must document the total dollar amount in the budget narrative within cooperative agreement funding applications. Recipients must be able to account for MOE separate from accounting for federal funds and separate from accounting for any matching funds requirements; this accounting is subject to ongoing monitoring, oversight, and audit. MOE may not include any sub-recipient matching funds requirement where applicable.

MOE does not apply to future contingent emergency response awards that may be authorized under section 311 of the PHS Act unless such a requirement were imposed by statute or administrative process at the time.

## E. Special Requirements

### HPP General Funding Guidance

HPP funding must primarily support strengthening health care system preparedness through the collaborative development of HCCs that prepare and respond as an entire regional health system, rather than individual health care organizations. HPP recognizes that, at the conclusion of the previous project period (FY 2017-2018), some recipients only funded HCCs, some funded individual health care entities (with a requirement that they participate in regional preparedness efforts), and others funded a mixture of HCCs and individual health care entities.

During this project period (FY 2019-2023), beginning in FY 2019/budget period 1, all recipients must allocate at least a portion of funding to HCCs. For FY 2019/budget period 1, ASPR still permits providing

direct funding from the recipient to individual health care entities for regional preparedness efforts; however, ASPR requests that, as the project period progresses, recipients provide a greater percentage of their total award to HCCs each year over the five-year project period.

As recipients allocate more funding to HCCs each year, individual health care entities can continue to receive HPP funding, through the HCC, to ensure regional coordination and collaboration. HCCs will determine the amount of funding for health care entities upon review of coalition gaps and projects, as well as health care entity projects, based on the funding priorities for each FY/budget period. This process will ensure that HCC activities contribute to the overarching readiness, preparedness, and resilience of health care systems.

## Recipient Level Direct Costs

Recipients may retain direct costs for the management and monitoring of the HPP cooperative agreement during the FY 2019-2023 project period. Because the goal of HPP is to support HCCs and their health care system partners, in FY 2019/budget period 1, recipients must limit their costs for personnel, fringe benefits, and travel to no more than 18 percent of the HPP cooperative agreement award. HPP requests that recipients continue to strive to decrease these costs to allow more funds to be available to HCCs. By the end of FY 2023/budget period 5, recipients must limit these costs to no more than 15 percent of the HPP cooperative agreement award.

ASPR will consider requests for exemptions on a case-by-case basis. Requests for exemption must be submitted annually with the application (in Grants.gov) in the format of a letter to the HPP Director (please see contact information at the end of this announcement). The letter should contain the amount and percentage of funds the recipient requests to use for personnel, fringe benefits, and travel, and a justification explaining the reasons for the additional costs and the recipient's plan for reducing these costs in future fiscal years. Recipients must request exemptions with the application, as post-award exemption requests will not be accepted. Letters of support from the HCCs and the jurisdiction's hospital association will strengthen requests for exemption, indicating these entities understand and agree with the amount the recipient is retaining for personnel, fringe benefits, and travel.

## Funding Restrictions

Restrictions that must be considered while planning the programs and writing the budget are:

- Recipients may not use funds for research.

- Recipients may not use funds for clinical care except as allowed by law. For the purposes of this FOA, clinical care is defined as "directly managing the medical care and treatment of patients."

- Recipients may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.

- Generally, recipients may not use funds to purchase furniture or equipment. Any such proposed spending must be clearly identified in the budget.

- Pursuant to the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2019 (Public Law (PL)115-245), recipients may not use funds for lobbying activities:

  - Recipients shall not use any funds from an award made under this announcement for other than normal and recognized executive legislative relationships. Recipients shall not use funds for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video

presentation designed to support or defeat the enactment of legislation before the U.S. Congress or any state or local legislature or legislative body, except in presentation to the U.S. Congress or any state or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any state or local government, except in presentation to the executive branch of any state or local government itself.

o Recipients shall not use any funds from an award made under this announcement to pay the salary or expenses of any employee or subrecipient, or agent acting for you, related to any activity designed to influence the enactment of legislation, appropriations, regulations, administrative action, or executive order proposed or pending before the U.S. Congress or any state government, state legislature or local legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a state, local or tribal government in policymaking and administrative processes within the executive branch of that government.

o The above prohibitions include any activity to advocate or promote any proposed, pending, or future federal, state or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

  ▪ Recipients may not use funds to carry out any program of distributing sterile needles or syringes for hypodermic injections of any illegal drug.

  ▪ Recipients may not use funds to advocate or promote gun control.

  ▪ Recipients may not use funds for antibiotics for treatment of secondary infections.

  ▪ The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible.

  ▪ Recipients may not use funds for construction or major renovations.

  ▪ Recipients may supplement but not supplant existing state or federal funds for activities described in the budget.

  ▪ Recipients may not use funds for fundraising.

  ▪ Payment or reimbursement of backfilling costs for staff is not allowed.

  ▪ Recipients may not use funds for the cost of money even if part of the negotiated indirect cost rate agreement.

o Salaries may not exceed the rate of $189,600 USD per year: the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2019 (PL 115-245) limits the salary amount that recipients may award and charge to HHS/ASPR grants and cooperative agreements. Award funds should not be budgeted to pay the salary of an individual at a rate in excess of Executive Level II. Currently, the Executive Level II salary of the Federal Executive Pay scale is $189,600 USD. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to subawards/subcontracts under an HHS/ASPR grant or cooperative agreement.

o Funding under these awards may only be used for minor alteration and renovation (A&R) activities. Construction and major A&R activities are not permitted. A&R of real property generally is defined as work required to change the interior arrangements or installed

equipment in an existing facility so that it may be more effectively utilized for its currently designated purpose or be adapted for an alternative use to meet a programmatic requirement. The work may be categorized as improvement, conversion, rearrangement, rehabilitation, remodeling, or modernization, but it does not include expansion, new construction, development, or repair of parking lots, or activities that would change the "footprint" of an existing facility (e.g., relocation of existing exterior walls, roofs, or floors; attachment of fire escapes). Minor A&R may include activities and associated costs that will result in:

- Changes to physical characteristics (interior dimensions, surfaces, and finishes); internal environments (temperature, humidity, ventilation, and acoustics); or utility services (plumbing, electricity, gas, vacuum, and other laboratory fittings);

- Installation of fixed equipment (including casework, fume hoods, large autoclaves, biological safety cabinets);

- Replacement, removal, or reconfiguration of interior non-load bearing walls, doors, framed, or windows in order to place equipment in a permanent location;

- Making unfinished shell space suitable for purposes other than human occupancy, such as storage of pharmaceuticals; or,

- Alterations to meet requirements for accessibility by physically-disabled individuals.

o HPP funds may not be used to purchase clothing for promotional purposes, such as those items with recipient, HCC, and/or health care organization names/logos, as HPP funding is intended to address acute care patient surge. Clothing that can be used for personal protective equipment (PPE) and/or response purposes, and can be re-issued, may be purchased.

o Recipients may not use funds to purchase a house or other living quarters for those under quarantine, as HPP funding is intended to address acute care patient surge, and quarantine is a public health function rather than a patient care function.

o HPP recipients may (with prior approval) use funds for overtime for individuals directly associated (listed in personnel costs) with the award.

o HPP recipients cannot use funds to support standalone, single-facility exercises.

o HPP recipients cannot spend HPP funds on training courses, exercises, and planning resources when similar offerings are available at no cost.

**HPP Vehicle Purchase**

*Non-public road vehicles:*

- HPP grant funds can (with prior approval) be used to purchase HCC material-handling equipment such as industrial or warehouse-use trucks to be used to move HCC materials, supplies and equipment (such as forklifts, lift trucks, turret trucks, etc.). Vehicles must be of a type not licensed to travel on public roads.

**HPP Vehicle Leasing and Hauling Agreements**

*Passenger road vehicles:*

- HPP grant funds cannot be used to purchase over-the-road passenger vehicles.

- HPP grant funds can (with prior approval) be used to procure leased or rental vehicles as means of transportation for carrying people (e.g., passenger cars or trucks) during times of

need. Examples include transporting HCC leadership to planning meetings, to an exercise, or during a response.

*Transportation of medical material:*

- HPP grant funds can (with prior approval) be used to procure leased or rental vehicles for movement of materials, supplies and equipment by HCC members.

- Additionally, HPP grant funds can (with prior approval) be used for HCCs to make transportation agreements with commercial carriers for movement of HCC materials, supplies and equipment. There should be a written process for initiating transportation agreements (e.g., contracts, memoranda of understanding, formal written agreements, and/or other letters of agreement). Transportation agreements should include, at a minimum, the following elements:

  - Type of vendor

  - Number and type of vehicles, including vehicle load capacity and configuration

  - Number and type of drivers, including certification of drivers

  - Number and type of support personnel

  - Vendor's response time

  - Vendor's ability to maintain cold chain, if necessary to the incident

  This relationship may be demonstrated by a signed transportation agreement or documentation of transportation planning meeting with the designated vendor. All documentation should be available to the FPO for review if requested.

## Deployment of HPP-Funded Personnel, Equipment, and Supplies during Emergencies via the Emergency Management Assistance Compact (EMAC)

Deployment of HPP-funded equipment, supplies and personnel via EMAC for the purpose of mutual aid and assistance between states during a governor-declared state of emergency or disaster is permitted, but is subject to the federal provisions of 45 CFR Part 75. However, affected recipients must notify their ASPR grants management specialist within a 24-hour period of the personnel, services and/or equipment being loaned out for the emergency. Recipients should follow their state legislation that governs how they will operate during an emergency or when another state requests assistance via EMAC. Recipients may reference the EMAC website for detailed information.

## Use of HPP Funds during a Declared Emergency

Consistent with section 319C-2 of the PHS Act, HPP funds may only be used to support activities that prepare states for public health emergencies and to improve surge capacity. There are two situations when states (see definition) may use HPP funds during a state or locally-declared emergency, disaster, or public health emergency (hereafter referred to as an "emergency"). These situations and related criteria are described below.

### Situation 1: HPP Staff Conducting Activities Consistent with Approved Project Goals

Recipients may use HPP funds to support positions performing preparedness-related activities consistent with the recipient's project goals and may utilize those positions within any phase of the disaster cycle, provided that the staff members in those positions continue to do work within statutory limitations, the notice of award, and the approved spending plan. For example, an employee's salary may be permissible for response activities if that employee is carrying out the same responsibilities he or she would carry out as part of his or her preparedness responsibilities.

**Situation 2: Using a Declared Emergency as a Training Exercise**

Under certain conditions, HPP funds may, on a limited, case-by-case basis, be reallocated to support response activities to the extent they are used for purposes provided for in section 319C-2 of the PHS Act, applicable cost principles, the FOA, and the recipient's application (including the jurisdiction's all-hazards plan). Recipients should contact their assigned HPP FPO and grants management specialist for guidance on the process to make such a change. ASPR encourages recipients to develop criteria such as costs versus benefits for determining when to request a "scope-of-work" change to use a real incident as a required exercise.

The request to use an actual response as a required exercise and to pay salaries with HPP funds for up to seven (7) days will be considered for approval under these conditions:

- A state or local declaration of an emergency, disaster, or public health emergency is in effect.

- No other funds are available for the cost.

- The recipient agrees to submit within 60 days (of the conclusion of the disaster or public health emergency) an AAR, a corrective action plan, and other documentation that supports the actual dollar amount spent.

Note: A change in the scope of work is required to use an actual event as an exercise whether or not funds are needed to support salaries. Also, regardless of the amount of money used in response to an event, the state is still required to meet all the requirements of the original award.

**Use of HPP Funds for Establishing a Separate Legal Entity**

While allowable, establishment of HCCs as a separate legal entity is entirely voluntary and subject to the following directions and guidance. Use of any other organizational structures not addressed in this directive requires prior approval from appropriate HHS officials.

Several scenarios could occur when HCCs set up as a business. In the first two scenarios, listed below, the HCCs would be establishing a stand-alone company and follow all the laws, both state and federal, that apply to any business operating within the state. In the third scenario the state may establish a central body, either the state itself or with another agent, and have the HCCs serve as "chapters" across the state.

In all cases these legal entities must set up as a business and follow the standard business practices required of that type of organization. For example, a non-profit should have a Board of Directors that is legally responsible for all the undertakings of the company. If an HCC hires employees, they must meet all the payroll requirements including withholding and reporting of all associated taxes. The company will need to establish the policy and procedures required to administer the grant funds. The state must assure that the company has the financial capability to administer the grant funds, prior to issuing a subaward.

Prior approval to use the state HPP funds to support any costs regarding the setup of the organization is required, regardless of the total requested amount.

*Prior Approval Process*

Prior approval is required before using any HPP funds:

- to support the HCCs in establishing a non-profit organization, or

- before establishing the affiliated organization structure.

ASPR strongly advises that recipients work with their assigned HPP FPO and grants management specialist while developing the request.

*Associated Organization Costs*

Different organization costs are allowed depending on what type of company the HCCs are setting up.

- If an HCC forms a separate for-profit organization, including a limited liability corporation, then none of the associated organization costs may be paid for using the grant funds. (Source FAR Part 31.205-27))

- If an HCC forms a separate non-profit group the following organization costs, as stated in 2 CFR Part 230, may be approved costs:

Organization costs: Expenditures, such as:

- Incorporation fees,

- Brokers' fees,

- Fees to promoters, organizers or management consultants, attorneys, accountants, or investment counselors, whether or not employees of the organization, in connection with establishment or reorganization of an organization, are unallowable except with prior approval of the awarding agency.

If a state establishes a central body with the HCCs serving as "chapters" across the state, the HCC is then considered an affiliated organization and the following guides would apply.

*Affiliated organizations:* A number of universities and other organizations have established closely affiliated, but separately incorporated, organizations to facilitate the administration of research and other programs supported by federal funds. Such legally-independent entities are often referred to as "foundations," although this term does not necessarily appear in the name of the organization. Typically, the parent organization provides considerable support services to its "foundation" in the form of administration, facilities, equipment, accounting, and other services, and the latter, acting in its own right as a recipient, includes the cost of these services in its indirect cost proposal.

Costs incurred by an affiliated, but separate, legal entity in support of a recipient foundation (foundation) are allowable for reimbursement under HHS grants only if at least one of the following conditions is met:

- The foundation is charged for, and is legally obligated to pay for, the services provided by the parent organization.

- The affiliated organization is subject to state or local law that prescribes how federal reimbursement for the costs of the parent organization's services will be expended and requires that a state or local official acting in his or her official capacity approves such expenditures.

- There is a valid written agreement between the affiliated organizations whereby the parent organization agrees that the foundation may retain federal reimbursement of parent organization costs. The parent organization may either direct how the funds will be used or permit the foundation that discretion.

If none of the above conditions is met, the costs of the services provided by the parent organization to the foundation are not allowable for reimbursement under an HHS grant. However, the services may be acceptable for cost sharing (matching) purposes. (Source: HHS Grants Policy Statement (GPS) Services Provided by Affiliated Organizations (II 45)).

Approval by appropriate HHS officials is required for any other scenario under which an HPP recipient or sub-recipient HCC may seek to charge such costs to their award or sub-award under this option.

**HPP Funding Limitations for Individual Health Care Facilities**

Funding to individual health care entities is not permitted to be used to meet CMS conditions of

participation, including CMS-3178-F Medicare and Medicaid Programs: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers. CMS-3178-F requires providers and suppliers to meet the following conditions of participation.

- Develop an emergency plan: based on a risk assessment, develop an emergency plan using an all-hazards approach focusing on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters specific to the location of a provider or supplier. HPP funding may not be provided to individual health care entities to meet this requirement; however, ASPR encourages HCCs to provide TA to their individual members to assist them with the development of their emergency plans. HCCs are permitted to use HPP funding to develop the staffing capacity and technical expertise to assist their members with this requirement.

- Develop policies and procedures: develop and implement policies and procedures based on the plan and risk assessment. HPP funding may not be provided to individual health care entities to meet this requirement; however, ASPR encourages HCCs to provide TA to their individual members to assist them with the development of policies and procedures. HCCs are permitted to use HPP funding to develop the staffing capacity and technical expertise to assist their members with this requirement.

- Develop and maintain a communication plan: develop and maintain a communication plan that complies with both federal and state law. Patient care must be well-coordinated within the facility, across health care providers, and with state and local public health departments and emergency systems. HPP funding may not be provided to individual health care entities to meet this requirement; however, ASPR encourages HCCs to provide TA to their individual members to assist them with the development a communication plan that integrates with the HCC's communications policies and procedures. HCCs are permitted to use HPP funding for costs associated with adding new providers and suppliers to their HCC who are seeking to join coalitions to coordinate patient care across providers, public health departments, and emergency systems (e.g., hiring additional staff to coordinate with the new members, providing communications equipment and platforms to new members, conducting communications exercises, securing meeting spaces, etc.)

- Develop and maintain a training and testing program: develop and maintain training and testing programs, including initial and annual trainings, and conduct drills and exercises or participate in an actual incident that tests the plan. HPP funding may not be provided to individual health care entities for individual health care organizations' trainings and exercises. HPP funding may be used to plan and conduct trainings and exercises at the regional or HCC level.

# IV. APPLICATION AND SUBMISSION INFORMATION

## A. Address to Request Application Package

Application materials can be obtained from the Grants.gov webpage.

Contact person regarding this FOA is:

Melissa Harvey, RN, MSPH

Director, Hospital Preparedness Program

202-692-4673

Melissa.Harvey@hhs.gov

Applicants must download the application package associated with this funding opportunity from Grants.gov. If the applicant encounters technical difficulties with Grants.gov, the applicant should contact Grants.gov customer service. The Grants.gov contact center is available 24 hours a day, 7 days a week, with the exception of all federal holidays. The contact center provides customer service to the applicant community. The extended hours will provide applicants support around the clock, ensuring the best possible customer service is received any time it is needed. You can reach the grants.gov support center at 1-800-518-4726 or by email at support@grants.gov. Submissions sent by email, fax, CDs, or thumb drives of applications will not be accepted.

Applicants are encouraged to submit their application prior to the due date.

## B. Required Registrations

Applicants must register with the System for Award Management (SAM) and Grants.gov (see below for all registration requirements).

### 1. Get Registered

You are required to complete three (3) registration processes:

1. Dun & Bradstreet Data Universal Numbering System (DUNS) (to obtain a DUNS number);
2. System for Award Management (SAM); and
3. Grants.gov

If this is your first time submitting an application, you must complete all three registration processes. If you have already completed registrations for DUNS and SAM, you need to ensure that your accounts are still active, and then register in Grants.gov. **If your organization is not registered by the deadline, the application will not be accepted.** The organization must maintain an active and up-to-date SAM and DUNS registrations in order for ASPR to make an award.

### a. DUNS Registration

Applicants are required to obtain a valid DUNS number, also known as the unique entity identifier, and provide that number in the application. Obtaining a DUNS number is easy and there is no charge.

To obtain a DUNS number, access the Dun and Bradstreet website or call 1-866-705-5711. To expedite the process, let Dun and Bradstreet know that you are a public/private non-profit organization getting ready to submit a federal grant application. **The DUNS number you use on your application must be registered and active in the SAM.**

### b. SAM Registration

You must also register with the SAM and continue to maintain active SAM registration with current information during the period of time your organization has an active federal award or an application under consideration by an agency. To create a SAM user account, register/update your account, and/or search records go to the SAM website.

ASPR also highly recommends that you renew your account prior to the expiration date. SAM information must be active and up-to-date, and should be updated at least every 12 months to remain active (for both recipients and sub-recipients). Once you update your record in SAM, it will take 48 to

72 hours to complete the validation processes. Grants.gov rejects electronic submissions from applicants with expired registrations.

### c.  Grants.gov Registration

Grants.gov is an online portal for submitting federal grant applications. It requires a one-time registration in order to submit applications. While Grants.gov registration is a one-time only registration process, it consists of multiple sub-registration processes (i.e., DUNS number and SAM registrations) before you can submit your application.

- You can visit the Grants.gov registration webpage to obtain a Grants.gov username and password.

If this is your first time submitting an application through Grants.gov, registration information can be found at the Grants.gov "Applicants" tab.

The person submitting your application must be properly registered with Grants.gov as the authorized organization representative for the specific DUNS number cited on the Standard Form 424 (SF-424) (first page). See the organization registration user guide for details on the organization registration page on Grants.gov.

All entities must register and/or renew registration with Grants.gov prior to submitting an application. Recipients previously registered must assure that the registration is still valid and up-to-date. Registration and re-registration take up to 10 working days to process. Failure to submit the application on time due to late registration will result in ASPR not accepting the application.

## C. Application Screening Criteria

Applications must be submitted electronically via the Grants.gov webpage by 05/03/2019 at 11:59 p.m. ET.

**Content and Form of Application Submission**

Applicants are required to include all of the following documents with their application package on the Grants.gov webpage. The following required documents and sections must be included in the application package in order to be considered for funding. The applicant can upload the documents as portable document format (PDF) files as part of their application on the Grants.gov webpage. Applicants may not attach documents other than those listed; if other documents are attached, applications will not be reviewed. Please ensure that the budget request associated with various activities is clearly delineated. Additional guidance can be found in the FY 2019 HPP Application Instructions.

- Table of Contents for Entire Submission
- Project Abstract Summary
- Project Narrative
- Detailed FY 2019/Budget Period 1 Work Plan
- Budget Narrative
- Application for Federal Assistance (SF-424)
- Budget Information for Non-Construction Programs (SF-424A)
- Indirect Cost Rate Agreement

- MYTEP – HPP plan
- EMSC support letter
- Disclosure of Lobbying Activities (SF-LLL)
- HPP Sub-recipient Scope of Work
- HPP Organizational Chart

Optional attachments:

- Memorandum of Agreement (MOA)
- Memorandum of Understanding (MOU)
- Recipient Level Direct Costs (RLDC) Waiver Request
- Isolated Hospital Classification Request

### *Table of Contents*

(There is no page limit for the table of contents. The table of contents is not included in the project narrative 20-page limit.) The applicant must provide, as a separate attachment, the "Table of Contents" for the entire submission package.

Provide a detailed table of contents for the entire submission package that includes all of the documents in the application and headings in the "Project Narrative" section. Name the file "Table of Contents" and upload it as a PDF file under "Other Attachment Forms" at Grants.gov.

### *Project Abstract Summary*

(Maximum 1 page) A project abstract must be submitted on the Grants.gov webpage. The project abstract must be a self-contained, brief summary of the proposed project including the purpose and outcomes. This summary must not include any proprietary or confidential information. Applicants must enter the project abstract in the "Project Abstract Summary" text box at Grants.gov.

### *Project Narrative*

(Maximum of 20 pages, single-spaced, 12-point font, 1-inch margins, number all pages. This includes the high-level work plan. Content beyond 20 pages will not be reviewed.)

Applicants must submit a Project Narrative with the application forms. Applicants must name this file "Project Narrative" and upload it on the Grants.gov webpage. **The Project Narrative must include all of the following headings (including subheadings): Background, Approach, Applicant Evaluation and Performance Measurement Plan, Organizational Capacity of Applicant to Implement Approach, and High-Level Work Plan.** The Project Narrative must be succinct, self-explanatory, and in the order outlined in this section. It must address the activities to be conducted over the entire project period. Failure to follow the guidance and format may negatively impact the review of the application.

The components of the Project Narrative counted as part of the 20-page limit include:

a. Background

   Applicants must provide a description of relevant background information that includes the context of the problem. The core background information must help reviewers understand how the applicant's response to the FOA will address the health care system problem and support health care system priorities. (See ASPR Executive Summary and Background).

b. Approach

i. Purpose

Applicants must describe in 2-3 sentences specifically how their application will address the augmentation of health care delivery system readiness and response as described in the ASPR Executive Summary and Background and Purpose sections.

ii. Objectives and Activities

Applicants must provide a clear and concise description of the activities they will use to achieve the HPP objectives and project period outcomes. Applicants must select evidence-based activities that meet their needs, or describe in the Applicant Evaluation and Performance Measurement Plan how these activities will be evaluated over the course of the project period. See the Objectives and Activities in Appendix A and Appendix C.

iii. Collaborations

Applicants must describe how they will collaborate with programs and organizations both internal and external to ASPR. Applicants must address the collaboration requirements as described in the ASPR funding opportunity description.

iv. Target Populations and Health Disparities

The applicant must also address how they will include specific target and at-risk populations that can benefit from the program. Applicants must address, at minimum, the target populations and health disparities requirements as described in the ASPR funding opportunity description.

c. Applicant Evaluation and Performance Measure Plan

At the time of application, applicants must include in their project narrative a brief description of how they plan to fulfill the requirements described in the evaluation and performance measurement and implementation sections of this FOA (including the requirements listed in appendices A and C). Applicants should briefly outline how they will evaluate and measure sub-recipient performance.

Recipients will be required to report on the ASPR-defined performance measures listed in Appendix D that will demonstrate, or show progress toward, the accomplishment of program outcomes.

Applicants should describe in a brief narrative a plan to affirm and acknowledge the recipient's ability to collect and respond to required ASPR-defined performance measures. For example, recipients may describe who will be monitoring and responding to required performance measures, potential data sources, anticipated barriers and challenges and how these will be resolved. Recipients may also describe how evaluation data will be shared with key stakeholders and used by the recipient to improve program quality and demonstrate the value of this funding.

d. Organizational Capacity of Applicant to Implement the Approach

Applicants must address their ability to successfully implement the proposed project and associated activities, including describing staff and other infrastructure already in place in which to build upon, to meet project period outcomes.

In addition, applicants must provide a copy of the organizational charts for their HPP activities. Applicants must name this file "HPP Organizational Chart" and upload it as a PDF file at Grants.gov. The organizational chart is not counted as part of the project narrative 20-page limit.

e. High-Level Work Plan

Applicants must prepare a high-level work plan that describes the proposed objectives and proposed activities for the five-year project period. The high-level work plan integrates and delineates more specifically how the applicant plans to achieve the project period objectives and activities, including

evaluation and performance measurement. Applicant must name this file "High-Level Work Plan" and upload it as a PDF file at Grants.gov. The high-level work plan should crosswalk to the objectives and activities and evaluation and performance measures described in the FOA.

## *Detailed FY 2019/Budget Period 1 Work Plan*

Applicants must develop and submit a detailed FY 2019/budget period 1 work plan that describes their planned activities for addressing the Objectives and Activities described in Appendix A and Appendix C, including:

- Application Requirements
- Capabilities
- Objectives and planned activities
- HPP readiness and operations phase

Applicants will complete the detailed FY 2019/budget period 1 work plan in PERFORMS and save it. Applicants must name the file "Detailed FY 2019/Budget Period 1 Work Plan" and upload it as a separate PDF file at Grants.gov with the other application documentation. The Detailed FY 2019/budget period 1 work plan will not be counted toward the project narrative 20-page limit.

ASPR recommends applicants approach the development of their work plans based on the most recently completed Capabilities Planning Guide (CPG) self-assessment that incorporates their current jurisdictional risk assessments and priorities (jurisdictional HVA, jurisdictional risk assessment (JRA), or Threat and Hazard Identification and Risk  Assessment (THIRA) as well as state-specific data in the NHSPI). Applicants must also ensure planned activities adhere to PHS Act, HPP requirements, and HPP-PHEP joint activities. ASPR encourages recipients to build and sustain each capability to the scale that best meets their jurisdictional needs, so they are fully capable of responding to public health emergencies, regardless of size or scenario.

## *Sub-recipient Scope of Work*

Applicants must briefly outline scope of work, planned activities, and intended outcomes and outputs of work performed via sub-recipient contracts, per capability. This is required for each intended sub-recipient (e.g., HCC, information system vendor, etc.). **The applicant must upload the sub-recipient scope of work in PERFORMS**. An optional sub-recipient scope of work template is available in the PERFORMS Resource Library.

## *Budget Narrative*

Applicants must submit an itemized budget narrative. Applicant must name this file "Budget Narrative" and upload it as a PDF file at Grants.gov. When developing the budget narrative, applicants must consider whether the proposed budget is reasonable and consistent with the purpose,  outcomes, and program strategy outlined in the project narrative.  The budget must include:

- Salaries and wages
- Fringe benefits
- Consultant costs
- Equipment
- Supplies
- Travel

- Other categories
- Contractual costs
- Total direct costs
- Total indirect costs

Indirect costs could include the cost of collecting, managing, sharing and preserving data. Indirect costs will not be reimbursed under grants to foreign organizations, international organizations, and foreign components of grants to domestic organizations (does not affect indirect cost reimbursement to the domestic entity for domestic activities).

- If indirect costs are requested, it will be necessary to include a copy of the organization's current negotiated Federal Indirect Cost Rate Agreement or a Cost Allocation Plan for those recipients under such a plan.
- Travel for program implementation should be justified and related to implementation activities.
- Budgets that include costs for equipment (e.g., laboratory or waste management equipment) must be detailed in the budget narrative.

### *Additional Information*

Additional information may be included as application appendices. The appendices must be uploaded to the "Other Attachments Form" of the application package in Grants.gov. Note: appendices will not be counted toward the project narrative 20-page limit.

### Submission Deadline Dates and Times

The deadline for the submission of applications under this FOA is 05/03/2019 at 11:59 p.m. ET. Applications must be submitted electronically via Grants.gov by 11:59 p.m. Eastern Time on 05/03/2019. Applications that are submitted after the deadline will not be processed.

Dates for Informational Conference Calls

- Joint HPP-PHEP informational conference call on March 6, 2019, 2:00 p.m. to 3:30 p.m. ET
- HPP-only informational conference call on March 11, 2019, 2:00 p.m. to 3:30 p.m. ET
- HPP-only informational conference call on March 18, 2019, 1:00 p.m. to 2:30 p.m. ET

Call information will be provided prior to the calls.

### Intergovernmental Review

This FOA is not subject to the requirements of Executive Order 12372, "Intergovernmental Review of Federal Programs."

## V. APPLICATION REVIEW INFORMATION

## Hospital Preparedness Program Cooperative Agreement

This FOA is for the continued purpose of strengthening and enhancing the capabilities of state, local, and territorial health care systems to respond effectively to evolving threats and other emergencies within the United States and territories and freely associated states. This announcement provides clear expectations and

priorities for recipients and HCCs to strengthen and enhance the readiness of the health care delivery system to save lives during emergencies that exceed the day-to-day capacity and capability of the public health and medical emergency response systems.

**Review and Selection Process**

Applications will be reviewed in three phases.

### a. Phase 1 Review

All applications will be initially reviewed for eligibility and completeness by ASPR grants management officials. Complete applications will be reviewed for responsiveness by the grants management officials and program officials. Non-responsive applications will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility and/or published submission requirements.

### b. Phase II Review

A programmatic review panel will evaluate complete, eligible applications in accordance with the criteria below.

#### i. Approach

ASPR will evaluate the extent to which the applicant:

- Describes overall objectives and activities.

- Describes objectives and activities that are achievable, appropriate to achieve the outcomes of the project, and evidence-based (to the degree practicable).

- Shows that the proposed use of funds is an efficient and effective way to implement the objectives and activities and attain the project period outcomes.

- Presents a work plan that is aligned with the objectives/activities, outcomes, and performance measures in the approach and is consistent with the content and format proposed by ASPR.

#### ii. Evaluation and Performance Measurement

ASPR will evaluate the extent to which the applicant:

- Shows/affirms the ability to collect data on the process and outcome performance measures specified by ASPR and presented by the applicant in their approach.

- Describes clear monitoring and evaluation procedure and how evaluation and performance measurement will be incorporated into planning, implementation, and reporting of project activities.

- Describes how performance measurement and evaluation findings will be reported and used to demonstrate the outcomes of the FOA and for continuous program quality improvement.

- Describes how evaluation and performance measurement will contribute to developing an evidence base for programs that lack a strong effectiveness evidence base.

#### iii. Applicant's Organizational Capacity to Implement the Approach

ASPR will evaluate the extent to which the applicant addresses the items below:

- Demonstrated relevant experience and capacity (management, administrative, and technical) to implement the activities and achieve the project outcomes.

- Demonstrates experience and capacity to implement the evaluation plan.
- Provides a staffing plan and project management structure that will be sufficient to achieve the project outcomes and which clearly defines staff roles. Provides an organizational chart.

ASPR will conduct a thorough technical review of work plans and budgets to ensure they align with the objectives and activities described in this FOA.

**c. Phase III Review**

The final phase will be completed by ASPR Grants Management.

**Review of risk posed by applicants**

Prior to making a federal award, ASPR is required by 31 USC 3321 and 41 USC 2313 to review information available through any Office of Management and Budget (OMB)-designated repositories of government-wide eligibility qualification or financial integrity information as appropriate. See also suspension and debarment requirements at 2 CFR Parts 180 and 376.

In accordance 41 USC 2313, ASPR is required to review the non-public segment of the OMB-designated integrity and performance system accessible through SAM (currently the Federal Recipient Performance and Integrity Information System (FAPIIS)) prior to making a federal award where the federal share is expected to exceed the simplified acquisition threshold, defined in 41 USC 134, over the period of performance. At a minimum, the information in the system for a prior federal award recipient must demonstrate a satisfactory record of executing programs or activities under federal grants, cooperative agreements, or procurement awards; and integrity and business ethics. ASPR may make a federal award to a recipient who does not fully meet these standards, if it is determined that the information is not relevant to the current federal award under consideration or there are specific conditions that can appropriately mitigate the effects of the non-federal entity's risk in accordance with 45 CFR §75.207.

ASPR's framework for evaluating the risks posed by an applicant may incorporate results of the evaluation of the applicant's eligibility or the quality of its application. If it is determined that a federal award will be made, special conditions that correspond to the degree of risk assessed may be applied to the federal award. The evaluation criteria are described in this FOA. In evaluating risks posed by applicants, ASPR will use a risk-based approach and may consider any items such as the following:

1) Financial stability;
2) Quality of management systems and ability to meet the management standards prescribed in this part;
3) History of performance. The applicant's record in managing federal awards, if it is a prior recipient of federal awards, including timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous federal awards, and if applicable, the extent to which any previously awarded amounts will be expended prior to future awards;
4) Reports and findings from audits performed under subpart F of 45 CFR Part 75 or the reports and findings of any other available audits; and
5) The applicant's ability to effectively implement statutory, regulatory, or other requirements imposed on non-federal entities.

ASPR must comply with the guidelines on government-wide suspension and debarment in 2 CFR Part 180, and require non-federal entities to comply with these provisions. These provisions restrict federal awards, subawards, and contracts with certain parties that are debarred, suspended or otherwise excluded from or ineligible for participation in federal programs or activities.

# VI: AWARD ADMINISTRATION INFORMATION

## A. Award Notices

The Notice of Award is the authorizing document from the ASPR authorizing official, within the Office of Resource Management. The Notice of Award will be sent electronically upon successful review of the application. The Notice of Award sets forth the amount of funds granted, the terms and conditions of the award, the effective date of the award, the budget period for which initial support will be given, the non-federal share to be provided (if applicable), and the total project period for which support is contemplated.

## B. Administrative and National Policy Requirements

The award is subject to OMB 2 CFR Part 200 (subparts A through D), HHS administrative requirements, which can be found in 45 CFR Part 75 and the standard terms and conditions implemented through the HHS Grants Policy Statement (GPS) located at on the HHS Grants Policies & Regulations webpage.

Please note HHS plans to revise the HHS GPS to reflect changes to the regulations; 45 CFR Parts 74 and 92 have been superseded by 45 CFR Part 75.

### Non-Discrimination Requirements

Pursuant to federal civil rights laws, if you receive an award under this announcement you must not discriminate on the basis of race, color, national origin, disability, age, and in some cases sex and religion. The HHS Office for Civil Rights (OCR) provides guidance to recipients in complying with civil rights laws that prohibit discrimination on their OCR webpage. HHS provides guidance to recipients of federal financial assistance on meeting the legal obligation to take reasonable steps to provide meaningful access to persons with limited English proficiency. See *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, 68 Fed. Reg. 47311, 47313, HHS OCR 2003, or on the HHS OCR guidance webpage. You must ensure your contractors and sub-recipients also comply with federal civil rights laws.

### Smoke- and Tobacco-free Workplace

The HHS/ASPR strongly encourages all grant recipients to provide a smoke-free workplace and to promote the non-use of all tobacco products. This is consistent with the HHS/ASPR mission to protect and advance the physical and mental health of the American people.

### ASPR Public Access Policy

The ASPR Public Access Policy requires all researchers receiving ASPR grants, cooperative agreements, or fixed amount awards to develop data management plans describing how they will provide for the long-term preservation of, and access to, scientific data in digital format. This ASPR Public Access Policy applies to any manuscript that is peer-reviewed and arises from any direct funding from an ASPR grant, cooperative agreement or fixed amount award awarded in FY 2016 or beyond. This policy ensures that the public has access to the published results of ASPR funded grants, cooperative agreements, and fixed amount awards at the National Institutes of Health (NIH) National Library of Medicine PubMed Central (PMC), a free digital archive of full-text biomedical and life sciences journal literature. Under the policy, ASPR-funded investigators are required by federal law to submit (or have submitted for them) to PMC an electronic version of the final, peer-reviewed manuscript upon acceptance for publication, to be made publicly available no later than 12 months after the official date of publication. On February 22, 2013, the White House Office of Science and Technology Policy released the memorandum entitled, Increasing Access to the Results of

Federally Funded Scientific Research, which requires federal agencies to make the results of federally-funded scientific research available to and useful for the public, industry, and the scientific community. This document establishes a governing policy to enable public access to digitally formatted scientific data created with ASPR funds.

### Publications

Manuscripts resulting from funded work must be submitted directly to the [NIH Manuscript Submission System (NIHMS)](#). At the time of submission, the submitting author must specify the date the final manuscript will be publicly accessible through PMC. Authors may own the original copyrights to materials they write and should work with the prospective publisher as necessary before any rights are transferred to ensure that all conditions of the ASPR Public Access Policy can be met. Authors should avoid signing any agreements with publishers that do not allow the author to comply with the ASPR Public Access Policy. The author's final peer-reviewed manuscript is defined as the final version accepted for journal publication, and includes all modifications from the publishing peer review process, and all graphics and supplemental material associated with the article. Institutions and investigators are responsible for ensuring that any publishing or copyright agreements concerning submitted articles reserve adequate right to fully comply with this policy. Applicants citing articles in ASPR applications, proposals, and progress reports that fall under the policy, were authored or co-authored by the applicant and arose from ASPR support must include the PMC ID or NIHMS ID. The NIHMS ID may be used to indicate compliance with the ASPR's Public Access Policy in applications and progress reports for up to three months after a paper is published. After that period, a PMCID must be provided to demonstrate compliance.

### Digital Data

ASPR-supported researchers must publish digital scientific data sets resulting from projects meeting the scope criteria above in a recognized scientific data repository capable of long-term preservation of the data and open access to the public within a proscribed time period of 30 months from the creation of the data set (if the data set has not been used in a peer-reviewed publication) or upon publication of a peer-reviewed publication based on the data set, whichever is sooner, unless this requirement has been waived in the approved data management plan. ASPR will recognize intellectual property rights as appropriate, consistent with regulations and program policies, including considerations for intellectual property based on the type of data subject to those policies (e.g., varied embargo dates, conditions for delaying data release). For the purpose of this plan, proprietary interests include receiving appropriate credit for scientific work. If the outcomes of the research result in inventions, the provisions of the Bayh-Dole Act of 1980, as implemented in 37 CFR Part 401, apply.

### Acknowledgement

ASPR Public Access Policy requires that all recipient publications including research publications, press releases, other publications or documents about research that is funded by ASPR to include the following two statements:

A specific acknowledgment of ASPR grant support, such as: *"Research reported in this [publication/press release] was supported by [name of the program office(s), or other ASPR offices] the Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response under award number [specific ASPR grant number(s)]."* A disclaimer that says: *"The content is solely the responsibility of the authors and does not necessarily represent the official views of the Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response."*

## Trafficking in Persons

Awards issued under this funding opportunity announcement are subject to the requirements of section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 USC 7104). For the full text of the award term, go to the [Office Population Affair's Trafficking in Persons](#) webpage. If you are unable to access this link, please contact the grants management specialist identified in this FOA to obtain a copy of the term.

# C. Reporting

**Progress Reporting:** Applicants funded under this announcement will be required to electronically submit via GrantSolutions program progress reports. As part of the progress report, financial information may be required per major category of expense, and by objectives.

**Subaward and Executive Compensation Reporting:** Applicants must ensure that they have the necessary processes and systems in place to comply with the subaward and executive total compensation reporting requirements established under OMB guidance at [2 CFR Part 170](#), unless they qualify for an exception from the requirements, should they be selected for funding.

**Quarterly Cash Transaction Reporting**: Applicants funded under this announcement will be required to electronically submit cash transaction data through Federal Financial Report (FFR) SF-425 via GrantSolutions (GS). Recipients will receive instructions for submitting these reports with their Notice of Award. Final performance and financial reports are due 90 days after the end of the project period.

**Federal Disbursement Reporting**: The SF-425 will also be used for reporting of expenditure data to meet ASPR's financial reporting requirement. It should be completed and submitted via GrantSolutions.

**Tangible Property Report**: Recipients will be required to submit an annual Tangible Property Report (SF-428) at the time the annual SF-425 is submitted to ASPR. Final SF-428 reports are due 90 days after the end of the project period.

**Audits:** If your organization receives $750,000 or greater of federal funds, it must undergo an independent audit in accordance with 45 CFR Part 75, subpart F or regulations and policy effective at the time of the award.

**Other Reporting Requirements:** Reporting provides continuous program monitoring and identifies successes and challenges that recipients encounter throughout the project period. Also, reporting is a requirement for recipients who want to apply for yearly continuation of funding. Reporting helps ASPR and recipients because it:

- Helps target support to recipients;

- Provides ASPR with periodic data to monitor recipient progress toward meeting the FOA outcomes and overall performance;

- Allows ASPR to track performance measures and evaluation findings for continuous quality and program improvement throughout the project period; and

- Enables ASPR to assess the overall effectiveness and influence of the FOA.

The table below summarizes required reports. All required reports must be submitted electronically via GrantSolutions. In addition, reports may be electronically sent to the grants management official listed in the "Agency Contacts" section of the FOA and with a copy to the HPP FPO.

| Report | Date | Required |
|---|---|---|
| **Annual Performance Report** | No later than 120 days before end of budget period. Serves as yearly continuation application. | Yes |
| **Federal Financial Reporting Forms** | 90 days after end of calendar quarter in which budget period ends | Yes |
| **Final Performance and Financial Report** | 90 days after end of project period | Yes |
| **Payment Management System (PMS) Reporting** | Quarterly | Yes |

**Annual Performance Report (required)**

The recipient must submit the APR electronically via GrantSolutions no later than 120 days before the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but web links are allowed. This report must include the following:

- **Performance Measures:** Recipients must report on performance measures for each FY/budget period and update measures, if needed. In addition, recipients must submit program benchmark and pandemic influenza planning data as described in the accountability provisions section. Recipients that fail to "substantially meet" HPP benchmarks and pandemic influenza planning information required by this FOA are subject to withholding of a statutorily mandated percentage of the following year's award.

- **Evaluation Results:** Recipients must report evaluation results for the work completed to date (including findings from process or outcome evaluations).

- **Work Plan:** Recipients must update their work plan each FY/budget period to reflect any changes in project period outcomes, activities, timeline, etc.

- **Successes**: Recipients must report progress on completing activities described in the work plan.

  - Recipients must describe any additional successes (e.g., identified through evaluation results or lessons learned) achieved in the past year.

  - Recipients must describe success stories (please see HPP in Action: Stories from the Field).

- **Challenges**

  - Recipients must describe any challenges that hindered or might hinder their ability to complete the work plan activities.

  - Recipients must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.

- **ASPR Support to Recipients**
  - Recipients must describe how ASPR could help them overcome challenges to complete activities in the work plan.

- **Administrative Reporting (No page limit)**
  - SF-424A Budget Information-Non-Construction Programs.
  - Budget Narrative – must use the format outlined in "Content and Form of Application Submission, Budget Narrative" section.
  - Indirect Cost Rate Agreement.

The recipients must submit the Annual Performance Report electronically via GrantSolutions 120 days before the end of the FY/budget period.

### Federal Financial Reporting (required)

The annual FFR form (SF-425) is required and must be submitted no later than 90 days after the end of the budget period. To submit the FFR, log into GrantSolutions, select "Reports" from the menu, and click on Federal Financial Reports. The report must include only those funds authorized and disbursed during the timeframe covered by the report. The final FFR must indicate the exact balance of unobligated funds, and may not reflect any unliquidated obligations. There must not be discrepancies between the final FFR expenditure data and the PMS cash transaction data. Failure to submit the required information by the due date may adversely affect the future funding of the project. If the information cannot be provided by the due date, recipients are required to submit a letter of explanation to ASPR grants management and include the date by which the grants officer will receive information. HPP may require more frequent financial reporting for HPP recipients based on individual circumstances.

### Final Performance and Financial Report (required)

This report is due 90 days after the end of the project period. This report should not exceed 40 pages. This report covers the entire project period and can include information previously reported in APRs. At a minimum, this report must include the following:

- Performance Measures – recipients must report final performance data for all performance measures.

- Evaluation Results – recipients must report final evaluation results for the project period for any evaluations conducted.

- Impact/Results/Success Stories – recipients must use their performance measure results and their evaluation findings to describe the effects or results of the work completed over the project period, and can include some success stories.

- Additional forms as described in the Notice of Award (e.g., Equipment Inventory Report, Final Invention Statement).

### Reporting of Matters Relating to Recipient Integrity and Performance

If the total value of your currently active grants, cooperative agreements, and procurement contracts from all federal awarding agencies exceeds $10,000,000 for any period of time during the period of performance of this federal award, then you must maintain the currency of information reported to the SAM that is made available in the designated integrity and performance system (currently the FAPIIS) about civil, criminal, or administrative proceedings described in paragraph 2 of Appendix XII to 2 CFR part 200—Award Term and Condition for Recipient Integrity and Performance Matters. This is a statutory

requirement under section 872 of PL 110-417, as amended (41 USC 2313). As required by section 3010 of PL 111-212, all information posted in the designated integrity and performance system on or after April 15, 2011, except past performance reviews required for federal procurement contracts, will be publicly available. For more information about this reporting requirement related to recipient integrity and performance matters, see Appendix XII to 2 CFR Part 200.

**Other Required Notifications**

Before you enter into a covered transaction at the primary tier, in accordance with 2 CFR § 180.335, you, as the participant, must notify ASPR if you know that you or any of the principals for that covered transaction:

a) Are presently excluded or disqualified;

b) Have been convicted within the preceding three years of any of the offenses listed in 2 CFR § 180.800(a) or had a civil judgment rendered against you for one of those offenses within that time period;

c) Are presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the offenses listed in 2 CFR § 180.800(a); or

d) Have had one or more public transactions (federal, state, or local) terminated within the preceding three years for cause or default.

At any time after you enter into a covered transaction, in accordance with 2 CFR § 180.350, you must give immediate written notice to HHS/ASPR if you learn either that—

a) You failed to disclose information earlier, as required by 2 CFR § 180.335; or

b) Due to changed circumstances, you or any of the principals for the transaction now meet any of the criteria in 2 CFR § 180.335.

**Federal Funding Accountability and Transparency Act (FFATA) and FFATA Subaward Reporting System (FSRS) Reporting**

FFATA requires data entry at the [FFATA Subaward Reporting System](#) webpage for all subawards and sub-contracts issued for $25,000 or more as well as addressing executive compensation for both recipient and subaward organizations.

# VII. AGENCY CONTACTS

## A. Grants Management Contact

For financial, awards management, or budget assistance, contact:

Virginia Simmons, Chief Grants Management Officer (CGMO)

U.S. Department of Health and Human Services

Office of the Assistant Secretary for Preparedness and Response

Office of Resource Management

200 C Street SW

Washington, DC  20515

Telephone: (202) 260-0400

Email: asprgrants@hhs.gov

## B. Program Office Contact

For **programmatic technical assistance**, contact:

Melissa Harvey, Director

U.S. Department of Health and Human Services

Office of the Assistant Secretary for Preparedness and Response

National Healthcare Preparedness Programs

200 C Street, SW

Washington, DC  20515

Telephone: (202) 692-4673

E-email: melissa.harvey@hhs.gov

# VIII. OTHER INFORMATION

## A. Appendices

- Appendix A: 2019-2023 HPP FOA Application Requirements and Capabilities, Objectives, and Activities
- Appendix B: Hospitals Within FAR Level 4 Locales
- Appendix C: 2019-2023 HPP FOA Capabilities, Objectives, and Activities for Territories, Freely Associated States, and Isolated Frontier Hospitals
- Appendix D: FY2019 HPP Performance Measures

## B. Attachments

- Attachment 1: Instructions for Completing Required Forms (SF-424, Budget (SF-424A), Budget Narrative/Justification)

## HPP Fiscal Year 2019/Budget Period 1 Funding

| Recipient | FY 2019 Total Funding Available |
|---|---|
| **Alabama** | $3,101,457 |
| **Alaska** | $1,097,949 |
| **American Samoa** | $276,077 |
| **Arizona** | $4,704,562 |
| **Arkansas** | $2,073,408 |
| **California** | $23,274,780 |
| **Chicago** | $2,742,281 |
| **Colorado** | $3,255,651 |
| **Connecticut** | $2,241,789 |
| **Delaware** | $1,069,426 |
| **Florida** | $11,823,573 |
| **Georgia** | $7,984,714 |
| **Guam** | $344,674 |
| **Hawaii** | $1,272,454 |
| **Idaho** | $1,306,270 |
| **Illinois** | $8,808,313 |
| **Indiana** | $3,927,515 |
| **Iowa** | $2,040,550 |
| **Kansas** | $2,002,917 |
| **Kentucky** | $2,851,105 |
| **Los Angeles County** | $9,155,013 |
| **Louisiana** | $2,990,820 |
| **Maine** | $1,107,031 |
| **Marshall Islands** | $269,480 |
| **Maryland** | $5,134,799 |
| **Massachusetts** | $4,069,878 |
| **Michigan** | $5,770,572 |
| **Micronesia** | $282,682 |
| **Minnesota** | $3,376,813 |
| **Mississippi** | $2,038,196 |

| | |
|---|---|
| **Missouri** | $3,636,821 |
| **Montana** | $1,090,377 |
| **Nebraska** | $1,398,788 |
| **Nevada** | $2,593,012 |
| **New Hampshire** | $1,098,617 |
| **New Jersey** | $5,369,840 |
| **New Mexico** | $1,590,617 |
| **New York** | $9,864,244 |
| **New York City** | $7,501,609 |
| **North Carolina** | $6,086,316 |
| **North Dakota** | $1,063,632 |
| **Northern Mariana Islands** | $276,615 |
| **Ohio** | $7,072,358 |
| **Oklahoma** | $2,510,199 |
| **Oregon** | $2,588,708 |
| **Palau** | $256,518 |
| **Pennsylvania** | $7,728,428 |
| **Puerto Rico** | $2,596,212 |
| **Rhode Island** | $1,063,672 |
| **South Carolina** | $3,139,944 |
| **South Dakota** | $1,071,504 |
| **Tennessee** | $4,004,671 |
| **Texas** | $15,493,193 |
| **Utah** | $2,368,945 |
| **Vermont** | $1,066,451 |
| **Virgin Islands (US)** | $303,699 |
| **Virginia** | $6,897,199 |
| **Washington** | $4,336,358 |
| **Washington, DC** | $1,148,960 |
| **West Virginia** | $1,404,726 |
| **Wisconsin** | $3,416,869 |
| **Wyoming** | $1,066,149 |
| **Total FY 2019 HPP Funding** | **$231,500,000** |

## Appendix A: 2019-2023 HPP FOA Application Requirements and Capabilities, Objectives, and Activities

As described in the introductory sections on page 5, these requirements are organized primarily by phase. Therefore, activities are numerically listed as appropriate under each phase and not necessarily in ascending order.

| Application Requirements (formerly program activities) | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| Recipients must, with funding provided, refine and sustain HCCs through the end of the project period. | X | | All 5 | Reported under Program Requirements of Application |
| Recipients must submit each HCC's full scope of work (HCC Requirements) in PERFORMS with the application. | X | | All 5 | Reported under Program Requirements of Application<br><br>**Required Attachment (PERFORMS)** |
| Recipients must define the HCC boundaries. HCCs should consider daily health care delivery patterns, corporate health systems, and defined catchment areas, such as regional EMS councils, trauma regions, accountable care organizations, emergency management regions, etc., when defining boundaries.<br><br>ASPR recognizes that U.S. territories, freely associated states, and HCCs with isolated frontier communities may have limited health care infrastructure, face unique barriers, and do not include competitive health care organizations. Therefore, these recipients must describe their current health care utilization patterns, any geographic gaps in coverage, and all health care partners in detail including those connected to small islands or other land masses, atolls, and any available clinics/dispensaries, dialysis centers, nursing homes, etc. Additionally, they should detail estimated distances and travel times to the nearest partner | X | | All 5 | Reported under Program Requirements of Application AND provide any updates with APR |

| Application Requirements (formerly program activities) | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| facilities outside their immediate catchment area. U.S. territories and freely associated states' applications must also describe the structure and functions of their public health agency, emergency management organization, and EMS partners. | | | | |
| All U.S. territories and freely associated states must describe their geography and all health care facilities and services on the island(s). All recipients requesting classification for hospitals located in isolated/frontier communities must describe the geography surrounding those hospitals and how they will continue to integrate with neighboring HCCs. In addition, the recipient must describe how each HCC, including the hospital(s), is connected to the jurisdiction's ESF-8 medical surge structure, and describe where the governmental emergency operations center (EOC) is located and the person(s) responsible for staffing that position. | X | | All 5 | Reported under Program Requirements of Application AND provide any updates with APR |
| (Joint HPP/PHEP Activity) In collaboration with the PHEP program, HPP recipients must identify whether their jurisdictions have done the following: 1) Tested the following expedited procedures as identified in their plans    a) Receiving emergency funds during a real incident or exercise    b) Reducing the cycle time for contracting and procurement during a real incident or exercise 2) Implemented internal controls related to sub-recipient monitoring and any negative audit findings resulting from suboptimal internal controls 3) Tested emergency authorities and mechanisms as identified in their plans to reduce time for hiring or reassignment of staff (workforce surge). If they were tested, recipients should identify which procedures were tested and when, and describe the average times for recruitment and hiring of staff in routine and emergency circumstances. If recipients are unable to attest to these administrative preparedness capabilities, recipients must develop processes to improve on their administrative readiness and describe those | X | | All 5 | Reported under Program Requirements of Application AND provide any updates with APR |

| Application Requirements (formerly program activities) | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| improvements in their APR. | | | | |
| Recipients must maintain a current all-hazards public health and medical emergency preparedness and response plan that includes the following components:<br><br>• Recipients establish and maintain advisory committees or similar mechanisms of senior officials from governmental and non-governmental organizations involved in homeland security, health care, public health, EMS, and behavioral health to help integrate preparedness efforts across jurisdictions and to maximize funding streams.<br><br>• Recipients describe how they will use EMAC or other mutual aid agreements for medical and public health mutual aid to support coordinated activities and to share resources, facilities, services, and other potential support required when responding to emergencies that impact the public's health.<br><br>• ASPR is aware that FSM, RMI, and PW do not utilize EMAC, therefore, U.S. territories and freely associated states must also include descriptions of any mutual aid agreements (between U.S. territories and freely associated states, utilizing agreements with the U.S. Government (USG), United States Agency for International Development (USAID), Department of Interior (DOI), etc.) for public health and medical mutual aid.<br><br>• Recipients should submit their plans to ASPR and CDC when requested, and make it available for review during site visits. | X | | All 5 | Reported under Program Requirements of Application |

| Application Requirements (formerly program activities) | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| **(Joint HPP/PHEP Activity)** In collaboration with the PHEP program, HPP recipients, the HCCs, and their members must participate in current and future federal health care situational awareness initiatives for the duration of the project period.<br><br>• To reduce undue burden on recipients, HPP and PHEP will coordinate, both within HHS (CDC, HRSA, CMS, National Disaster Medical System (NDMS), etc.) and interagency partners (FEMA, VA, Department of Defense (DoD), etc.), to reduce the duplication of Health and Medical Requests for Information.<br><br>• Recipients and sub-recipients may provide information in any format utilized by their organization (e.g., SITREP, SPOTREP, etc.). ASPR will work to extract the EEIs. To further reduce burden on recipients, ASPR will work directly with any HCC unable to provide the requested health care specific information. | X | X | All 5 | Reported under Program Requirements of Application |
| HPP recipients must collaborate with the HRSA EMSC program within its jurisdiction to better meet the needs of children receiving emergency medical care.<br><br>HPP recipients and the EMSC program recipients within their jurisdictions must provide a joint letter of support indicating that EMSC and HPP are linked at the recipient level. The letter of support is required with their funding application at the beginning of each budget period throughout the five-year project period. | X | | All 5 | Reported under Program Requirements of Application<br><br>**Required Attachment (PERFORMS)** |
| Recipients will not use HPP funds for subawards with any HCC that presently does not meet the core membership requirements, as defined in the 2017-2022 Health Care Preparedness and Response Capabilities. ASPR understands HCCs may have different membership compositions based on population characteristics, geography, governmental structure, and types of local hazards, but each funded HCC must include, at least, the core members. | X | | All 5 | Reported under Program Requirements of Application |

## Capabilities, Objectives, and Activities

| CAPABILITY 1: Foundation for Health Care and Medical Readiness | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| **PHASE 1: Plan and Prepare** | | | | |
| Objective 1: Establish and Operationalize a Health Care Coalition (HCC) | | | | |
| Activity 2: Identify Health Care Coalition Members | | | | |
| The recipient, on behalf of the HCC(s), **must** make available a listing or provide access to a listing of all core members and additional coalition members as defined in the 2017-2022 Health Care Preparedness and Response Capabilities. | X | X | All 5 | Upload into PERFORMS |
| Core members should be represented at all HCC meetings, virtually or in-person. Core members should also sign all HCC-related documentation, such as governance, preparedness plans, response plans and recovery plans. Additionally, core members should participate in ALL HCC exercises. | | X | All 5 | Verify during Site Visit |
| Representation from additional functional entities is essential for the purpose of **supporting acute health care service delivery**. HCCs should recruit and incorporate these entities in their membership. These entities include, but are not limited to the following:<br>• Medical Supply Chain Organizations<br>• Pharmacies<br>• Blood Banks<br>• Clinical Labs<br>• Federal Health Care Organizations | | X | All 5 | Upload in CAT (Transfer agreements with pediatric, trauma, and burn centers should be incorporated into the corresponding specialty surge annex) |

| CAPABILITY 1: Foundation for Health Care and Medical Readiness | Recipient | HCC | Fiscal Year | Validation Method |
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| • Outpatient Care Centers<br>• Long Term Care Organizations<br><br>In addition, all HCC inpatient facilities not providing definitive specialty care should demonstrate transfer agreements with at least one receiving facility for:<br><br>• Pediatric Centers<br>• Trauma and Burn Center | | | | |
| Activity 3: Establish Health Care Coalition Governance | | | | |
| The HCC **must** update and maintain the following information related to its governance:<br><br>• HCC membership<br>• HCC should be led or co-led by hospitals or health care organization<br>• An organizational structure capable of supporting HCC activities<br>• Member guidelines for participation and engagement<br>• Policies and procedures focused on supporting acute health care service delivery through communication and coordination<br>• HCC integration with existing state, local, and member-specific incident management structures and roles. | | X | All 5 | Upload in CAT |

| CAPABILITY 1: Foundation for Health Care and Medical Readiness | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| All HCCs **must** fund **at least 1.0 full-time equivalent (FTE)** (combined and may include in-kind support of dedicated time) to support the following two staffing requirements:<br><br>• **Clinical Advisor:** individual(s) should be a physician, advanced practice provider, or registered nurse and should be from a lead or co-lead hospital or health care organization and be clinically active (i.e., works shifts/sees patients). Involvement in emergency services or response activities is preferred and knowledge of medical surge issues and basic familiarity with chemical, biological, radiological, nuclear, and explosives (CBRNE), trauma, burn, and pediatric emergency response principles is required. Role of the clinical advisor(s) is to:<br><br>1. Provide clinical leadership to the coalition and serve as a liaison between the coalition and medical directors/medical leadership at health care facilities, supporting entities (e.g., blood banks), and EMS agencies.<br><br>2. Review and provide input on coalition plans, exercises, and educational activities to assure clinical accuracy and relevance.<br><br>3. Act as an advocate and resource for other clinical staff to encourage their involvement and participation in coalition activities.<br><br>4. Assure that the coalition mass casualty/surge plans provide for appropriate distribution (and re-distribution) of trauma patients to avoid overloading single centers whenever possible and work with health care facilities to understand their capabilities and capacity.<br><br>5. Assure that subject matter experts are available and a process exists to support secondary transfer prioritization in specialty surge (e.g., burn, pediatric) mass casualty situations (i.e., identify which patients are a priority to transfer to specialty care centers | X | X | All 5 | Include in each HCC's Scope of Work submitted with the application<br><br>Submit with the HCC Budget Requirement or Recipient Budget with Application<br><br>Budget line should contain: Name, Position Title, Salary, %Time, and Parent Organization. |

| CAPABILITY 1: Foundation for Health Care and Medical Readiness | Recipient | HCC | Fiscal Year | Validation Method |
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| when adequate transportation or inpatient resources are unavailable). <br><br> • **HCC Readiness and Response Coordinator:** role of the coordinator is to facilitate the planning, training, exercising, operational readiness, financial sustainability, evaluation, and ongoing development of the HCC as well as to lead, participate in, or support the response activities of the coalition according to their plans. <br><br> ASPR recognizes this may require some HCCs to shift priorities to personnel rather than supplies/equipment in their budgets; however, ASPR believes that the value gained through the clinical and operational guidance, coordination, training, and exercise coordination these FTEs can provide is ESSENTIAL to an HCC's ongoing readiness and ability to respond. In the event the HCC has insufficient funds, recipients and HCCs should consider various funding solutions that include, but are not limited to, the following options: <br><br> • Reevaluation of the existing HCC funding formula or boundaries <br><br> • Formal agreement with the parent organization to utilize in-kind funding for a portion of the FTE <br><br> • Partner with a neighboring HCC to recruit and cost-share a clinical advisor when geographically and logistically appropriate | | | | |
| Objective 2: Identify Risks and Needs | | | | |
| Activity 1: Assess Hazard Vulnerability and Risks | | | | |
| Each funded HCC, in collaboration with the recipient, **must** annually update and maintain their HVA to identify risks and impacts. | | X | All 5 | Upload in CAT |
| All HCC-funded projects **must** be tied to a hazard or risk from the HCC's HVA, an identified capability gap, or an activity identified during a corrective action process. | | X | All 5 | Verified through HCC work plan and budget. |

| CAPABILITY 1: Foundation for Health Care and Medical Readiness | Recipient | HCC | Fiscal Year | Validation Method |
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| **(Joint HPP/PHEP Activity)** All HPP recipients should work with PHEP recipients to participate in or complete a JRA at least once every 5 years. | X | | Once every 5 years | Submit with APR |
| Activity 2: Assess Regional Health Care Resources | | | | |
| Each funded HCC **must** update and maintain a resource inventory assessment to identify health care resources and services at the jurisdictional and regional levels that could be coordinated and shared in an emergency. <br><br> HPP recipients should ensure that each HCC maintains visibility on their members' resources and resource needs, such as personnel, facilities, equipment, and supplies. | X | X | All 5 | Verify during Site Visit |
| Activity 4: Assess Community Planning for Children, Pregnant Women, Seniors, Individuals with Access and Functional Needs, People with Disabilities, and Others with Unique Needs | | | | |
| **(Joint HPP/PHEP Activity)** HPP and PHEP recipients should conduct inclusive risk planning throughout the project period for the whole of community including children, pregnant women, senior citizens, individuals with access and functional needs, including people with disabilities; individuals with pre-existing conditions; and others with unique needs and vulnerabilities. | X | | All 5 | Verify during Site Visit |
| **(Joint HPP/PHEP Activity)** HPP and PHEP recipients should involve each funded HCC and its members in risk planning. In addition, HPP and PHEP recipients are encouraged to involve experts in chronic conditions and maternal and child health in risk planning. | X | X | All 5 | Verify during Site Visit |
| ASPR strongly recommends that HPP recipients use the Agency for Toxic Substances and Disease Registry (ATSDR) Social Vulnerability Index, which helps identify risk factors and at-risk populations by geographic area. | X | | All 5 | Verify during Site Visit |

| CAPABILITY 1: Foundation for Health Care and Medical Readiness | Recipient | HCC | Fiscal Year | Validation Method |
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| As part of inclusive planning for populations at risk conducted by HPP recipients, HPP-funded HCCs should:<br><br>• Support HCC members with situational awareness and information technology (IT) tools already in use that can help identify children, seniors, pregnant women, people with disabilities, and others with unique needs.<br><br>• Support HCC member agencies in developing or augmenting existing response plans for these populations, including mechanisms for family reunification.<br><br>• Identify potential health care delivery system support for these populations (pre- and post-event) that can prevent stress on hospitals during a medical surge event.<br><br>• Assess needs and contribute to medical planning that may enable individuals to remain in their residences during certain emergencies. When that is not possible, coordinate with the jurisdiction's ESF-8 lead agency to support the jurisdiction's ESF-6 (Mass Care, Emergency Assistance, Housing, and Human Services) lead agency with access to medical care including at shelter sites.<br><br>• Coordinate with the jurisdiction's ESF-8 lead agency to assess medical transport needs for these populations. |  | X | All 5 | Verify during Site Visit |
| Objective 3: Develop a Health Care Coalition Preparedness Plan |  |  |  |  |
| Activity 1: Develop a Health Care Coalition Preparedness Plan |  |  |  |  |

| CAPABILITY 1: Foundation for Health Care and Medical Readiness | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| The HCC **must** update and maintain their preparedness plan annually and following major incidents or large-scale exercises. The plan must be approved by all its core member organizations. All of the HCC's additional member organizations should be given an opportunity to provide input into the preparedness plan, and all member organizations must receive a final copy of the plan. | | X | ALL 5 | Upload in CAT |
| To improve regional readiness and response coordination, HCCs located in jurisdictions with an identified Regional Disaster Health Response System (RDHRS) state or regional entity, should integrate strategies and tactics into their preparedness plan that promote communications, information sharing, resource coordination, and operational response planning between the HCC and the RDHRS entity. | | X | ALL 5 | Upload in CAT |
| Objective 5: Ensure Preparedness is Sustainable | | | | |
| Activity 3: Engage Clinicians | | | | |
| The HCC clinical advisor **must** engage health care delivery system clinical leaders to provide input, acknowledgement, and understanding of their facility and regional strategic and operational roles in acute medical surge planning to include CBRNE, trauma, burn, and pediatric readiness and response. Additionally, they should gain an understanding of the scope of specialized clinical expertise throughout the HCC and include clinicians from a wide range of specialties in HCC activities on a regular basis to validate medical surge plans and to provide subject matter expertise to ensure realistic training and exercises. | | X | All 5 | Verify during Site Visit |
| Activity 4: Engage Community Leaders | | | | |

| CAPABILITY 1: Foundation for Health Care and Medical Readiness | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| The HCC Readiness and Response Coordinator **must** identify and engage community leaders including businesses, charitable organizations, and the media, in health care preparedness planning and exercises to promote the resilience of the entire community. | | X | All 5 | Verify during Site Visit |
| Activity 5: Promote Sustainability of Health Care Coalitions | | | | |
| Sustainability planning is a critical component in HCC development. Strong governance, regional stakeholder engagement, and sound financial planning help to strengthen the HCC foundation and ensure future viability. HCCs should: <br><br>• Offer HCC members TA or consultative services in meeting the CMS Emergency Preparedness Rule: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers <br><br>• Develop materials that identify and articulate the benefits of HCC activities and promote preparedness efforts to both members and additional stakeholders such as health care executives, clinicians, community leaders, and other key audiences <br><br>• Explore ways to meet member's requirements for tax exemption through community benefit <br><br>• Analyze critical functions to preserve and identify financial opportunities (such as foundations and private funding, dues, and training fees) to support or expand HCC functions in case of decreased federal funding <br><br>• Develop a financing structure and document the funding sources that support HCC activities <br><br>• Determine ways to cost share with other organizations with similar requirements (such as coordinating required risk assessments or exercises with public health agencies and emergency management | | X | All 5 | Verify during Site Visit |

| CAPABILITY 1: Foundation for Health Care and Medical Readiness | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| organizations)<br>• Incorporate leadership succession planning into the HCC governance and structure<br>• Leverage group buying power to promote consistent equipment across a region to facilitate sharing or emergency allocation | | | | |
| **PHASE 2: Train and Equip** | | | | |
| Objective 4: Train and Prepare the Health Care and Medical Workforce | | | | |
| Activity 1: Promote Role-Appropriate NIMS Implementation | | | | |
| HPP recipients should ensure that HCCs assist their members with NIMS implementation throughout the project period. HCCs **must**:<br>• Ensure HCC leadership receives NIMS training based on evaluation of existing NIMS education levels and need<br>• Promote NIMS implementation among HCC members, including training and exercises, to facilitate operational coordination with public safety and emergency management organizations during an emergency using an incident command structure<br>• Assist HCC members with incorporating NIMS components into their emergency operations plans | X | X | All 5 | Include in sub-recipient contract; Verify during Site Visit |
| Activity 2: Educate and Train on Identified Preparedness and Response Gaps | | | | |

| CAPABILITY 1: Foundation for Health Care and Medical Readiness | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| HCCs **must** submit, with their annual work plan, a list of planned training activities relevant to identified risks, resource gaps, work plan priorities, and corrective actions from prior exercises and incidents. Training activities may include but are not limited to initial education, continuing education, appropriate certifications, and just-in-time training. Awareness and operational level training on all aspects of HCC functions focused on preparedness, response, and recovery should be conducted. | | X | All 5 | Upload to CAT |
| **PHASE 3: Exercise and Respond** | | | | |
| Objective 4: Train and Prepare the Health Care and Medical Workforce | | | | |
| Activity 3: Plan and Conduct Coordinated Exercises with Health Care Coalition Members and Other Response Organizations | | | | |
| **(Joint HPP/PHEP Activity)** HPP and PHEP recipients, and all HCCs, as part of a coordinated statewide effort, should conduct a joint statewide exercise (functional or full-scale exercise) once during the project period to test progress toward achieving the capabilities outlined in the 2017-2022 Health Care Preparedness and Response Capabilities and the Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health, and in collaboration with cross-border metropolitan statistical area/Cities Readiness Initiative regions.<br><br>All joint HPP and PHEP exercises, including MCM exercises, **must** include a surge of patients into the health care system. | X | X | Once during project period | AAR/IP Info submitted in PERFORMS with APR |
| Activity 4: Align Exercises with Federal Standards and Facility Regulatory and Accreditation Requirements | | | | |
| **PHASE 4: Evaluate and Share Lessons Learned** | | | | |

| CAPABILITY 2: Health Care and Medical Response Coordination | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| **PHASE 1: Plan and Prepare** | | | | |
| Objective 1: Develop and Coordinate Health Care Organization and Health Care Coalition Response Plans | | | | |
| Activity 2: Develop a Health Care Coalition Response Plan | | | | |
| **(Joint HPP/PHEP Activity)** Each HCC **must** coordinate the development of its response plan by involving core members and other HCC members so that, at a minimum, hospitals, EMS, emergency management organizations, and public health agencies are represented in the plan. Each HCC should review and update its response plan annually and following major incidents or large-scale exercises. The updated plan must be approved by all its core members. All of the HCC's additional member organizations should be given an opportunity to provide input into the response plan, and all member organizations must receive a final copy of the plan. | X | X | All 5 | Upload in CAT and submit updates to recipient |

| CAPABILITY 2: Health Care and Medical Response Coordination | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| **(Joint HPP/PHEP Activity)** Each HCC's response plan **must** describe the HCC's operational roles that support strategic planning, situational awareness, information sharing, and resource management. This includes, but is not limited to, the following:<br><br>• HCC integration with the jurisdiction's ESF-8 lead agency to ensure information is provided to local, state, and federal officials.<br><br>• The HCC's ability to effectively communicate and address resource needs requiring ESF-8 assistance. In cases where the HCC serves as the jurisdiction's ESF-8 lead agency, the HCC response plan may be the same as the ESF-8 response plan.<br><br>• The HCC's ability to support the increase of emergency and inpatient services to meet the demands of a medical surge event (with or without warning; short or long duration). All communities should be prepared to respond to conventional and mass violence trauma.<br><br>• The HCC's ability to determine bed, staffing, and resource availability; identify patient movement requirements; support acute care patient management and throughput; initiate and support crisis care plans.<br><br>• The provision of behavioral health support and services to patients, families, responders, and staff.<br><br>• The incorporation of available resources for management of mass fatalities through ESF8. | | X | All 5 | Upload in CAT |
| **(Joint HPP/PHEP Activity)** Recipient all-hazards public health and medical preparedness and response plans **must** specify coordination with their HCCs | X | X | All 5 | Verify during Site Visit |
| Objective 2: Utilize Information Sharing Processes and Platforms | | | | |
| Activity 1: Develop Information Sharing Procedures | | | | |

| CAPABILITY 2: Health Care and Medical Response Coordination | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| The HCC and its members **must**, at a minimum, define and integrate into their response plans procedures for sharing EEIs. This includes but is not limited to the current operational status of facilities, elements of electronic health records, and resource needs and availability.<br><br>ASPR will provide coordinated pre-event, post-event, and special event-specific EEIs required for integration and submission by recipients and sub-recipients by the end of the first quarter of FY 2019/budget period 1. | | X | All 5 | Upload in CAT; Included in Response Plans |
| **(Joint HPP/PHEP Activity)** HPP and PHEP recipients should work together to establish a common operating picture/situational awareness tool that facilitates coordinated information sharing among all public health, health care, HCCs, and relevant stakeholders. | X | | All 5 | Verify during Site Visit |
| **(Joint HPP/PHEP Activity)** By FY 2020, the HCC, in coordination with its public health agency members and HPP and PHEP recipients **must** develop processes and procedures to rapidly acquire and share clinical knowledge between health care providers and between health care organizations during responses. | X | X | 2020 | Verify during Site Visit |
| Activity 2: Identify Information Access and Data Protection Procedures | | | | |
| HPP recipients should verify that each HCC is able to access and collect timely, relevant, and actionable information about their members during emergencies. | X | | All 5 | Verify during Site Visit |
| Activity 3: Utilize Communications Systems and Platforms | | | | |
| **(Joint HPP/PHEP Activity)** HPP recipients should identify reliable, resilient, interoperable, and redundant information and communication systems and platforms, including those for bed availability, EMS data, and patient tracking, and provide access to HCC members and other stakeholders. | X | | All 5 | Verify during Site Visit; Included in Response Plans |
| **PHASE 2: Train and Equip** | | | | |

| CAPABILITY 2: Health Care and Medical Response Coordination | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| Objective 3: Coordinate Response Strategy, Resources, and Communications | | | | |
| Activity 4: Communicate with the Public During an Emergency | | | | |
| **(Joint HPP/PHEP Activity)** By FY 2021, the HCC, in collaboration with HPP and PHEP recipients, **must** provide public information officer (PIO) training to those who are designated to act in that capacity during an emergency for HCC members and are in need of such training. This training should include Crisis and Emergency Risk communication training. | X | X | 2021 | Verify during Site Visit |
| **PHASE 3: Exercise and Respond** | | | | |
| Objective 3: Coordinate Response Strategy, Resources, and Communications | | | | |
| Activity 1: Identify and Coordinate Resource Needs during an Emergency | | | | |
| To ensure the continuity of information flow and coordination activities, multiple employees from each HCC member organization **must** understand and have access to the HCC's information sharing platforms. | | X | All 5 | Verify during Site Visit |
| Activity 2: Coordinate Incident Action Planning During an Emergency | | | | |
| **(Joint HPP/PHEP Activity)** HCCs **must** provide a communication and coordination role within their respective jurisdictions. This coordination ensures the integration of health care delivery into the broader community incident planning objectives and strategy development. It also ensures that resource needs that cannot be managed within the HCC itself are rapidly passed along to the jurisdiction's ESF-8 lead agency. HCC coordination may occur at its own coordination center, the local EOC, or by virtual means – all of which are intended to interface with the jurisdiction's ESF-8 lead agency. HCCs should connect the medical response elements and provide the coordination mechanism among health care organizations, including hospitals and EMS, emergency management organizations, and public health agencies. | X | X | All 5 | Demonstrate during site visit; Included in Response Plans |

| CAPABILITY 2: Health Care and Medical Response Coordination | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| Activity 3: Communicate with Health Care Providers, Non-Clinical Staff, Patients, and Visitors During an Emergency | | | | |
| By FY 2021, each HCC should assist members with developing the ability to rapidly alert and notify their employees, patients, and visitors to provide situational awareness, protect their health and safety, and facilitate provider-to-provider communication | | X | 2021 | Demonstrate during site visit; Included in Response Plans |
| **PHASE 4: Evaluate and Share Lessons Learned** | | | | |

| CAPABILITY 3: Continuity of Health Care Service Delivery | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| **PHASE 1: Plan and Prepare** | | | | |
| Objective 2: Plan for Continuity of Operations | | | | |
| Activity 2: Develop a Health Care Coalition Continuity of Operations Plan | | | | |
| Each funded HCC **must** develop an HCC continuity of operations (COOP) plan that is informed by its members' COOP plans and, at a minimum, includes the following elements:<br><br>• Activation and response functions<br>• Multiple points of contact for each HCC member<br>• Orders of succession and delegations of authority for leadership continuity<br>• Immediate actions and assessments to be performed in case of disruptions<br>• Safety assessment and resource inventory to determine ongoing HCC | | X | 2021 | Upload in CAT |

| CAPABILITY 3: Continuity of Health Care Service Delivery | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| operations<br><br>• Redundant, replacement, or supplemental resources, including communications systems<br><br>• Strategies and priorities for addressing disruptions to mission critical systems such as electricity, water, and medical gases.<br><br>• List of essential records and forms, including locations of electronic and hard copies of each<br><br>HCC COOP plans may be stand-alone plans or incorporated into the HCC response plan as an annex. | | | | |
| Objective 3: Maintain Access to Non-Personnel Resources During an Emergency | | | | |
| Activity 1: Assess Supply Chain Integrity | | | | |

| CAPABILITY 3: Continuity of Health Care Service Delivery | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| HPP recipients and HCCs **must** conduct a supply chain integrity assessment to evaluate equipment and supplies that will be in demand during emergencies and develop mitigation strategies to address potential shortfalls.<br><br>Each individual HCC member should examine its supply chain vulnerabilities by collaborating with health care organizations, manufacturers, and distributors to determine access to critical supplies, amounts available in regional systems, and potential alternate delivery options in case access or infrastructure is compromised. HCCs should utilize this information to effectively coordinate with their jurisdiction's ESF-8 lead agency and across the region.<br><br>Elements of a supply chain integrity assessment include, but are not limited to, the following:<br><br>• Blood banks<br>• Medical gas suppliers<br>• Fuel suppliers<br>• Nutrition suppliers and food vendors<br>• Pharmaceutical vendors<br>• Leasing entities for biomedical and durable medical equipment<br>• Manufacturers and distributors for disposable supplies<br>• Manufacturers and distributors for PPE<br>• Hazardous waste removal services<br>• Laundry, linen, and housekeeping services and suppliers | X | X | 2021 | Submit with APR; Upload in CAT |
| Activity 2: Assess and Address Equipment, Supply, and Pharmaceutical Requirements | | | | |

| CAPABILITY 3: Continuity of Health Care Service Delivery | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| All HPP recipients, HCCs, or HCC members purchasing pharmaceuticals and other medical materiel or supplies (e.g., PPE) with HPP funds **must** document the following:<br>• Strategies for acquisition, storage, rotation with day-to-day supplies, and use<br>• Inventory Management Program Protocols for all cached material<br>• Policies relating to the activation and deployment of their stockpile<br>• Policies relating to the disposal of expired materials<br><br>ASPR encourages, when possible, regional procurement of PPE. This procurement approach may offer significant advantages in pricing and consistency for staff, especially when PPE is shared across health care organizations in an emergency. Additionally, in circumstances where HCC members are part of a larger corporate health system, a balance between corporate procurement and regional procurement should be considered. | X | X | All 5 | Should be included in purchaser's (recipient and HCC) work plan. Protocol required if purchasing material. Recipient protocol submitted in PERFORMS. HCC protocol submitted in the CAT. |
| Objective 6: Plan for Healthcare Evacuation and Relocation | | | | |
| Activity 1: Develop and Implement Evacuation and Relocation Plans | | | | |
| HPP recipients, HCCs, and HCC members should sustain or further develop their evacuation planning and response activities throughout the remainder of the five-year project period. | X | X | All 5 | Verify during Site Visit |
| Objective 7: Coordinate Health Care Delivery System Recovery | | | | |
| Activity 1: Plan for Health Care Delivery System Recovery | | | | |

| CAPABILITY 3: Continuity of Health Care Service Delivery | Recipient | HCC | Fiscal Year | Validation Method |
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| Each recipient, in collaboration with their HCCs, **must** develop a health care system recovery plan and submit it to ASPR by the end of fiscal year 2022. Recovery processes may be integrated into recipients' existing plans, such as an annex to their emergency operations plan, or developed as a separate standalone plan. Each recipient should review their recovery plan after exercises and major incidents to update the following:<br><br>• Coordinated goals and strategic priorities for the continued delivery of essential health care services, including behavioral health services and case management.<br><br>• HCC integration with the Health and Social Services Recovery Support Function lead agency to advocate for the needs of healthcare, ensure information sharing, and manage resource availability within and between disciplines and coalition stakeholders.<br><br>• Prioritization of critical infrastructure dependencies necessary for the recovery of health service delivery in the following sectors: Communications, Emergency Services, Energy, Food and Agriculture, Information Technology, Transportation Systems, and Water and Wastewater Systems.<br><br>• Impact assessment process including the collection of information, issues related to current operational trends and themes, and the process for relaying requests for assistance based on emerging or persistent needs.<br><br>• Stakeholder process to connect with recovery assistance programs including support with initial disaster cost estimation and assistance with state and federal disaster recovery funding application (if available). | X | | 2022 | Submit with APR |
| **PHASE 2: Train and Equip** | | | | |

| CAPABILITY 3: Continuity of Health Care Service Delivery | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| Objective 5: Protect Responder Safety and Health | | | | |
| Activity 1: Distribute Resources Required to Protect the Health Care Workforce | | | | |
| HCCs should support and promote regional PPE procurement that could offer significant advantages in pricing and consistency for staff, especially when PPE is shared across multiple health care organizations in an emergency. | | X | All 5 | Include in Preparedness Plan |
| Activity 2: Train and Exercise to Promote Responder Safety and Health | | | | |
| (Joint HPP/PHEP Activity) HPP and PHEP recipients, and HCCs, should equip, train, and provide resources necessary to protect responders, employees, and their families from hazards during response and recovery operations. PPE, MCMs, workplace violence training, psychological first aid training, and other interventions specific to an emergency are all necessary to protect responders and health care workers from illness or injury and should be readily available to the entire health care workforce. | X | X | All 5 | Include in HCC Training Plan; Verify during Site Visit |
| (Joint HPP/PHEP Activity) Recipients and HCCs should educate stakeholders on current policies and practices regarding the type of PPE necessary for various infectious pathogens, and the availability of PPE resources, to include stockpiling considerations, vendor-managed inventories, and the potential for reuse of equipment. | X | X | All 5 | Include in HCC Training Plan; Verify during Site Visit |
| PHASE 3: Exercise and Respond | | | | |
| PHASE 4: Evaluate and Share Lessons Learned | | | | |

| CAPABILITY 4: Medical Surge | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| **PHASE 1: Plan and Prepare** | | | | |
| Objective 1: Plan for a Medical Surge | | | | |
| Activity 1: Incorporate Medical Surge Planning into a Health Care Organization Emergency Operations Plan | | | | |
| **(Joint HPP/PHEP Activity)** HPP recipients, HCCs, and their members, **must** work together to manage staffing resources, including volunteers, within hospitals and other health care settings. This includes:<br><br>• Identifying situations that would require supplemental staffing in hospitals and leverage existing hospital and health system staff sharing agreements and resources, to include volunteers.<br><br>• Developing rapid credential verification processes to facilitate emergency response.<br><br>• Identifying and addressing to the extent possible volunteer liability, licensure, workers compensation, scope of practice, and third-party reimbursement issues that may deter volunteer use.<br><br>• Leveraging existing government and non-governmental volunteer registration programs, such as ESAR-VHP and MRC personnel, to identify and staff health care-centric roles during acute care medical surge response events. Examples of MRC health care-specific duties that can be funded by HPP include:<br><br>   1. Triage support staff<br>   2. Emergency Department staff<br>   3. Medical Shelter clinical staff<br>   4. Search and Rescue Medical staff<br>   5. Field hospital clinical staff | X | X | All 5 | Include in Preparedness and Response Plans; Verify during Site Visit |

| CAPABILITY 4: Medical Surge | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| • Incorporating hospital, HCC, jurisdictional, or state-based medical assistance teams into medical surge planning and response. | | | | |
| Hospitals that are members of HPP-funded HCCs and meet the eligibility criteria for participation in NDMS should enter into formal agreements with the NDMS. This is intended to improve the recipient's and HCC's surge capacity and enhance hospital preparedness in response to a medical surge event.<br><br>NDMS enrollment efforts should target local general acute care inpatient medical facilities if they express a desire to participate or possess key specialty beds. Other hospitals may be considered based on the locally available resources. NDMS participating medical facilities should be within a reasonable distance for patient transportation given the local road network and relevant traffic conditions, generally within a 75-mile radius of the managing Federal Coordination Center (FCC). Medical facilities beyond this distance may be accepted for enrollment at the discretion of the FCC Director. | | X | All 5 | Verify during Site Visit |
| In partnership with the NDMS Hospital Readiness Initiative, HPP-funded HCCs that have an FCC or NDMS receiving facilities within their established boundaries should prepare to receive and treat patients during a NDMS activation.<br><br>HCCs can invest HPP resources in the following areas:<br><br>• NDMS partner engagement activities<br>• Patient reception planning<br>• Patient reception training<br>• NDMS exercises that include coalition coordination<br>• Medical surge systems<br>• Decontamination resources | | X | All 5 | Verify during Site Visit |

| CAPABILITY 4: Medical Surge | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| • PPE<br>• CBRN monitoring devices | | | | |
| Activity 2: Incorporate Medical Surge into an Emergency Medical Services Emergency Operations Plan | | | | |
| EMS plans should incorporate disaster related dispatch, response, mutual aid and regional coordination, pre-hospital triage and treatment, transportation, supplies, and equipment. HPP funding is not authorized to support routine EMS administrative and operational requirements (e.g., certifications, state EMS medical director). | | X | All 5 | Verify during Site Visit |
| Activity 3: Incorporate Medical Surge into a Health Care Coalition Response Plan | | | | |

| CAPABILITY 4: Medical Surge | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| **(Joint HPP/PHEP Activity)** Recipients should proactively integrate all components of their state and local governments in MCM response planning and consider inclusion of the following strategies in their MCM plans.<br><br>• Consider utilizing HCCs and their member organizations to plan, receive, and dispense MCMs for use in post exposure prophylaxis and acute medical treatment to patients, responders, and employees and their household members during a medical surge emergency<br><br>• Consider using the National Guard as a potential resource for MCM distribution and dispensing operations and provide training for National Guard personnel designed to serve in this capacity<br><br>• Consider voluntary reassignment of state and local employees to participate in MCM mission areas<br><br>• In addition to state-funded personnel, the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA) provides the Secretary of the Department of Health and Human Services (HHS) with discretion to authorize the temporary reassignment of federally funded state, tribal, and local personnel during a declared Federal Public Health Emergency upon request by a state or tribal organization; the temporary reassignment provision is applicable to state, tribal, and local public health department or agency personnel whose positions are funded, in full or part, under PHS Act programs and allows such personnel to immediately respond to the public health emergency in the affected jurisdiction (Please note: this authority is not currently effective as of the FOA publication date; however, if Congress reauthorizes the authority, recipients could consider it in their plans.)<br><br>• Explore with HHS whether federal workers providing direct assistance to state or regional offices may be eligible to assist with state and local MCM dispensing operations in their jurisdictions. | X | | All 5 | Verify during Site Visit |

| CAPABILITY 4: Medical Surge | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| HCCs should serve as planning resources and subject matter experts to PHEP recipients and public health agencies as they develop or augment existing response plans for affected populations, including mechanisms for family reunification. These plans should give consideration to:<br><br>• Information needs and a processes to reunify families (e.g., Health Insurance Portability and Accountability Act of 1996 exemptions)<br><br>• Reunification considerations for children<br><br>• Family notification and initiation of reunification processes. | | X | All 5 | Verify during Site Visit |
| HCCs **must** develop complementary coalition-level annexes to their base medical surge/trauma mass casualty response plan(s) to manage a large number of casualties with specific needs. Recipients should incorporate the HCC annexes into their jurisdiction's plan for awareness and to support coordination of state resources. In addition to the usual information management and resource coordination functions, each specialty surge annex framework should be similarly formatted and emphasize the following core elements:<br><br>• Indicators/triggers and alerting/notifications of a specialty event<br><br>• Initial coordination mechanism and information gathering to determine impact and specialty needs<br><br>• Documentation of available local, state, and interstate resources that can support the specialty response and key resource gaps that may require external support (including inpatient and outpatient resources)<br><br>• Access to subject matter experts – local, regional, and national<br><br>• Prioritization method for specialty patient transfers (e.g., which patients are most suited for transfer to a specialty facility)<br><br>• Relevant baseline or just-in-time training to support specialty care | | X | All 5 | Submit with APR; Upload in CAT |

| CAPABILITY 4: Medical Surge | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| • Evaluation and exercise plan for the specialty function | | | | |
| **Pediatric** – in addition to the above consider:<br>• Local risks for pediatric-specific mass casualty events (e.g., schools, transportation accidents)<br>• Age-appropriate medical supplies<br>• Mental health and age-appropriate support resources<br>• Pediatric/Neonatal Intensive Care Unit (NICU) evacuation resources and coalition plan<br>• Coordination mechanisms with dedicated children's hospital(s) | | | 2019 | |
| **Burn** – in addition to the above consider:<br>• Local risks for mass burn events (e.g., pipelines, industrial, terrorist, transportation accidents)<br>• Burn-specific medical supplies<br>• Coordination mechanisms with American Burn Association (ABA) centers/region<br>• Incorporation of critical care air/ground assets suitable for burn patient transfer | | | 2020 | |

| CAPABILITY 4: Medical Surge | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| **Infectious disease** – in addition to the above consider: <br><br> • Expanding existing Ebola concept of operations plans (CONOPs) to enhance preparedness and response for all novel/high consequence infectious diseases <br><br> • Developing coalition-level anthrax response plans <br><br> • Developing coalition-level pandemic response plans <br><br> • Including healthcare-associated infection (HAI) professionals at the health care facility and jurisdictional levels in planning, training, and exercises/drills <br><br> • Developing a continuous screening process for acute care patients and integrate information with electronic health records (EHRs) where possible in HCC member facilities and organizations <br><br> • Coordinating visitor policies for infectious disease emergencies at member facilities to ensure uniformity <br><br> • Coordinating MCM distribution and use by health care facilities for prophylaxis and acute patient treatment <br><br> • Developing and exercising plans to coordinate patient distribution for highly pathogenic respiratory viruses and other highly transmissible infections, including complicated and critically ill infectious disease patients, when tertiary care facilities or designated facilities are not available | | | 2021 | |

| CAPABILITY 4: Medical Surge | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| **Radiation** – in addition to the above consider:<br><br>• Local risks for radiation mass casualty events (e.g., power plant, industrial/research, radiological dispersal device, nuclear detonation)<br><br>• Detection and dosimetry equipment for EMS/hospitals<br><br>• Decontamination protocols<br><br>• On-scene triage/screening, assembly center, and community reception center activities<br><br>• Treatment protocols/information<br><br>• Coordination mechanisms with hematology/oncology centers and Radiation Injury Treatment Network (RITN) | | | 2022 | |
| **Chemical** – in addition to the above consider:<br><br>• Determine risks for community chemical events (e.g., industrial, terrorist, transportation-related)<br><br>• Decontamination assets and throughput (pre-hospital and hospital) including capacity for dry decontamination<br><br>• Determine EMS and hospital PPE for HAZMAT events<br><br>• Review and update Chempack (and/or other chemical countermeasure) mobilization and distribution plan<br><br>• Coordinate training for their members on the provision of wet and dry decontamination and screening to differentiate exposed from unexposed patients<br><br>• Ensure involvement and coordination with regional HAZMAT resources (where available) including EMS, fire service, health care organizations, and public health agencies (for public messaging)<br><br>• Develop plans for a community reception center with public health | | | 2023 | |

| CAPABILITY 4: Medical Surge | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| partners | | | | |
| HPP recipients **must** submit a new or updated Crisis Standards of Care CONOPS that integrates the following elements as applicable:<br><br>• Ethical considerations and the state subject matter experts for consultation and engagement during emergencies<br><br>• Guidance for EMS and health care providers on recommended crisis care strategies<br><br>• Community and provider engagement, education, and communication activities (completed and planned)<br><br>• Indicators and triggers for state activation and the actions the state will take to support prolonged crisis care conditions that cannot be rapidly addressed through standard mutual aid or other mechanisms<br><br>• Operational framework for state level information management and policy development including real-time engagement of subject | X | | 2020 | Submit with APR |

| CAPABILITY 4: Medical Surge | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| matter experts for technical support with allocation decisions and the coordination and decision processes for the allocation of scarce resources (e.g., pharmaceuticals or PPE) to the health and medical sector.<br><br>• Legal and regulatory state actions to be taken (as well as proposed changes to regulations/statute) that can support health care strategies during catastrophic/crisis care conditions, to include:<br><br>1. State declarations and their powers<br><br>2. Credentialing and licensure support for intra-state and inter-state assistance<br><br>3. Provider protection from liability during disasters<br><br>4. Support for alternate systems of care practices both in health care facilities and alternate environments<br><br>5. Relief from specific regulations that may impede appropriate billing and collection for services rendered under crisis conditions<br><br>6. State agency support for crisis care (e.g., EMS regulatory agency relief, hospital licensure requirements, state fire marshal) | | | | |

| CAPABILITY 4: Medical Surge | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| Each funded HCC **must** collaborate with the recipient to integrate the following crisis care elements into their response plan.<br><br>• Integration with state-level efforts<br><br>• Management of crisis conditions through regional coordination, including resource sharing and patient distribution<br><br>• Management of information and policy decisions with the assistance of the coalition partners during a protracted event<br><br>• Management of resource requests and scarce resource allocation decisions when the demand cannot currently be met<br><br>• Support EMS agency planning for indicators, triggers, and response strategies during crisis conditions<br><br>• Support hospital planning for indicators, triggers, and response strategies during crisis conditions<br><br>• Transition to contingency care by requesting resources or moving patients to other facilities.<br><br>• Integration of crisis care/crisis standards of care conditions into exercises | | X | 2021 | Upload in CAT |
| **PHASE 2: Train and Equip (No associated HPP requirements)** | | | | |
| **PHASE 3: Exercise and Respond** | | | | |
| Objective 1: Plan for a Medical Surge | | | | |
| Activity 3. Incorporate Medical Surge into a Health Care Coalition Response Plan | | | | |

| CAPABILITY 4: Medical Surge | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| By FY 2021, the recipient's Crisis Standards of Care CONOPS Plan **must** be incorporated and validated in an HCC-level exercise. Principal focus should be on policy and scarce resource coordination. | X | X | 2021 | Submit with APR |
| Objective 2: Respond to a Medical Surge | | | | |
| Activity 1: Implement Emergency Department and Inpatient Medical Surge Response | | | | |
| **(Joint HHP/PHEP Activity)** HPP and PHEP recipients should coordinate the identification, recruitment, registration, training, and engagement of volunteers to support the jurisdiction's response to incidents.<br><br>HPP recipients and HCC should incorporate the use of volunteers to support acute care medical surge response training, drills, and exercises throughout the five-year project period. | X | X | All 5 | Verify during Site Visit |
| At least once during the project period, HCCs with an FCC **must** participate in the NDMS patient movement exercise. | | X | Once in the project period | Upload in CAT; Roles should be included in HCC Response Plan |

| CAPABILITY 4: Medical Surge | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| HCCs **must** complete the HCC Surge Estimator Tool by January 1, 2020, to support determination of their surge capacity. Only hospitals that provide emergency services will be included. HCCs will *NOT* submit individual hospital metric information to ASPR. Information will be aggregated at the coalition level. There are three distinct variables that vary significantly between hospitals and drive rapid development of surge capacity:<br><br>1) **Use of all available "staffed" beds** – including closed units that could be rapidly re-opened with appropriate staff (but are otherwise equipped and appropriate for inpatient care)<br><br>2) **Use of pre-induction, post-anesthesia, and procedural area beds** – can be used for temporary inpatient boarding/care usually at an intermediate care (telemetry) or higher level<br><br>3) **Surge discharge** – the ability to generate space or reduce the numbers of patients requiring evacuation by early discharge of appropriate current inpatients.<br><br>HCCs will review and update their HCC Surge Estimator Tool data at a minimum of every 2 years, but are encouraged to update upon any major changes in their HCC membership. | | X | January 1, 2020/ 2022/ 2024 | Upload in CAT |
| Activity 3: Develop an Alternate Care System | | | | |
| HPP recipient and HCC response plans should coordinate the use of alternate care systems, in collaboration with state and local public health agencies and emergency management organizations, prior to the conclusion of FY 2021. HPP recipients and HCCs should incorporate additional factors in their alternate care system activities prior to the conclusion of FY 2021:<br><br>• Establishment of telemedicine or virtual medicine capabilities<br><br>• Establishment of assessment and screening centers for early treatment | X | X | 2021 | Upload in CAT; Verify during Site Visit |

| CAPABILITY 4: Medical Surge | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| • Assisting with the selection and operation of alternate care sites | | | | |
| **(Joint HPP/PHEP Activity)** The coordination and planning for shelter medical care may be a primary responsibility of public health agencies based on the incident and their jurisdictional role. PHEP recipients should coordinate with HCCs and their members to address the public health, medical, and mental health needs of those impacted by an incident at congregate locations. HPP recipients should serve as subject matter experts to PHEP recipients on the health care needs of those impacted by an incident. | X | X | All 5 | Verify during Site Visit |
| Activity 4: Provide Pediatric Care During a Medical Surge Response | | | | |
| Recipient and HCCs **must** validate their Pediatric Care Surge Annex via a standardized tabletop/discussion exercise format and submit the results and data sheet to ASPR. | X | X | 2019 | Submit with APR; Upload in CAT |
| Activity 5: Provide Surge Management During a Chemical or Radiation Emergency Event | | | | |
| Recipient and HCCs **must** validate their Radiation Emergency Surge Annex via a standardized tabletop/discussion exercise format and submit the results and data sheet to ASPR. | X | X | 2022 | Submit with APR; Upload in CAT |
| Recipient and HCCs **must** validate their Chemical Emergency Surge Annex via a standardized tabletop/discussion exercise format and submit the results and data sheet to ASPR. | X | X | 2023 | Submit with APR; Upload in CAT |
| Activity 6: Provide Burn Care During a Medical Surge Response | | | | |
| Recipient and HCCs **must** validate their Burn Care Surge Annex via a standardized tabletop/discussion exercise format and submit the results and data sheet to ASPR. | X | X | 2020 | Submit with APR; Upload in CAT |

| CAPABILITY 4: Medical Surge | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| Activity 9: Enhance Infectious Disease Preparedness and Surge Response | | | | |
| Recipient and HCCs **must** validate their Infectious Disease Preparedness and Surge Annex via a standardized tabletop/discussion exercise format and submit the results and data sheet to ASPR. | X | X | 2021 | Submit with APR; Upload in CAT |
| **(Joint HPP/PHEP Activity)** During an infectious disease outbreak, ASPR and CDC **require** that recipients and HCCs coordinate the following activities to ensure the ability to surge to meet the demands during a highly infectious disease response:<br><br>• Establish a Medical Common Operating Picture<br><br>• Develop or update plans accordingly<br><br>• Establish key indicators and EEIs<br><br>• Provide real-time information sharing<br><br>• Coordinate public messaging | X | X | All 5 | Verify during an infectious disease outbreak |
| **(Joint HPP/PHEP Activity)** ASPR and CDC recommend the following **joint activities**:<br><br>• HCCs and state HAI multidisciplinary advisory groups or similar infection control groups within the state should partner to develop a statewide plan for improving infection control within health care organizations.<br><br>• Jurisdictional public health infection control and prevention programs including HAI programs and HCC members should jointly develop infectious disease response plans for managing individual cases and larger emerging infectious disease outbreaks.<br><br>• HPP and PHEP recipients, HCCs, and their members should collaborate on informatics initiatives such as electronic laboratory reporting, electronic test ordering, electronic case reporting, | X | X | | Verify during an infectious disease outbreak |

| CAPABILITY 4: Medical Surge | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| electronic death reporting, and syndromic surveillance.<br><br>• HPP and PHEP recipients and HCCs should engage with the community to improve understanding of issues related to infection prevention measures, such as changes in hospital visitation policies, social distancing, and infection control practices in hospitals, such as PPE use, hand hygiene, source control, and isolation of patients.<br><br>• HPP and PHEP recipients, HCCs, and their members should promote coordinated training and maintenance of competencies among public health first responders, health care providers, EMS, and others as appropriate, on the use of PPE, environmental decontamination, and management of infectious waste. Training should follow OSHA and state regulations.<br><br>• HPP and PHEP recipients, HCCs and their members should collaborate to develop and implement strategies to ensure availability of effective supplies of PPE, including:<br><br>   1. Working with suppliers and coalitions to develop plans for caching or redistribution and sharing<br><br>   2. Informing each other and integrating plans for purchasing, caching, and distributing PPE<br><br>• HPP and PHEP recipients, HCCs, and their members should sustain planning for the management of Persons Under Investigation (PUIs) to:<br><br>   1. Monitor health care personnel who may have had an exposure to a PUI by directly treating or caring for a PUI in a health care setting<br><br>   2. Clarify roles and responsibilities for key response activities related to the monitoring of PUIs<br><br>   3. Assisting or assessing readiness of health care organizations | | | | |

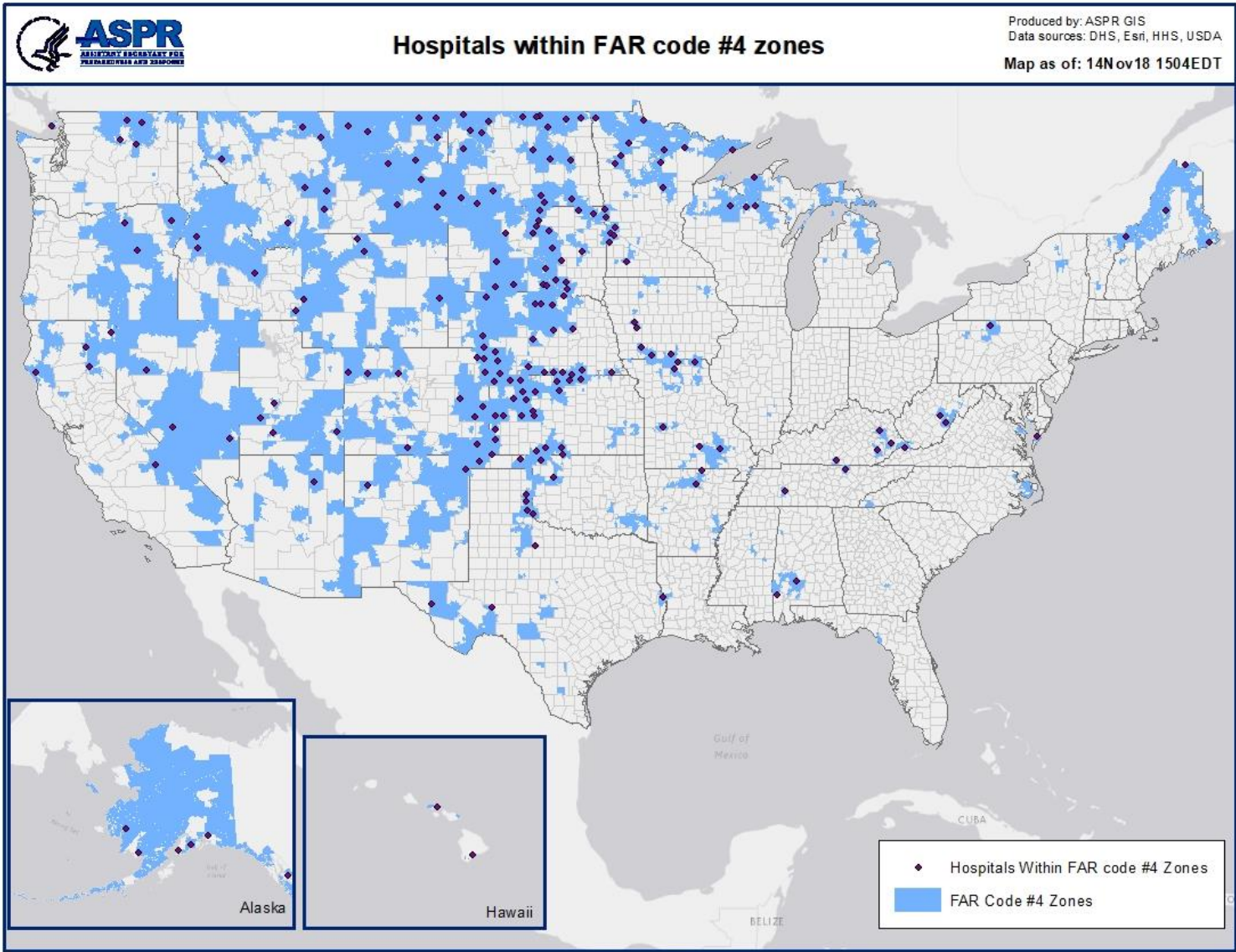| CAPABILITY 4: Medical Surge | Recipient | HCC | Fiscal Year | Validation Method |
|---|---|---|---|---|
| in the event of a PUI and<br><br>4. Conducting AARs and testing plans for PUI management to identify opportunities to improve local, state, and national response activities. | | | | |
| **PHASE 4: Evaluate and Share Lessons Learned (No associated HPP requirements)** | | | | |

# Appendix B: Hospitals Within FAR Level 4 Locales



**Figure 2. Map of the U.S. with geographic locations of hospitals within FAR level 4 locales.**

# Appendix C: 2019-2023 HPP FOA Capabilities, Objectives, and Activities for Territories, Freely Associated States, and Isolated Frontier Hospitals

**Background:**

This document applies to the following U.S. territories and the freely associated states:

- American Samoa (AS)
- Commonwealth of Northern Mariana Islands (CNMI)
- U.S. Virgin Islands (USVI)
- Territory of Guam
- Federated States of Micronesia (FSM)
- Republic of Palau (PW)
- Republic of the Marshall Islands (RMI)

It also applies to isolated frontier hospitals that reside within the Frontier and Remote Area Code, level 4, and have hospitals that are at least 60 miles apart.

The U.S. territories, freely associated states, and isolated frontier hospitals discussed in this appendix are each unique in their geographic location, physical infrastructure and health care resource limitations. Additionally, health care delivery and coordination of preparedness and response components are primarily, or in part, government-centered. This shapes the development and operations of all health care facilities and HCCs that are aligned to these jurisdictions' political or geographic boundaries.

ASPR recognizes the ability for health care facilities to be resilient and maintaining continuity of patient care and business operations is vital. Many of the activities outlined in the FOA remain applicable to U.S. territories, freely associated states, and isolated frontier hospitals and should be addressed by their local HCCs or individual health care facilities. Although these recipients are encouraged to address all HPP activities outlined in the HPP FOA, including the use of HCCs for coordinating health care situational awareness, planning, training, and exercising, they may require the flexibility to focus their planning, training, and exercising activities at the health care facility. All deadlines for the modified activities identified below are identical to the deadlines listed in main body of the FOA. To better facilitate support for these efforts, recipients have the ability to provide direct funding to health care facilities for the purposes of strengthening their individual capability and capacity to support acute care medical surge events.

**Purpose:**

U.S. territories, freely associated states, and isolated frontier hospital personnel managing the HPP cooperative agreement awards **must** apply the additional information, explanation, and guidelines provided under each of the following Health Care Preparedness and Response Capabilities, Objectives, and Activities and meet the overall FOA requirements for the 2019-2023 project period.

U.S. territories, freely associated states, and isolated frontier hospitals must work to meet all other administrative, financial, programmatic assurances, and requirements found in the FOA unless stated otherwise.

# Capabilities, Objectives, and Activity Requirements

# Capability 1: Foundation for Health Care and Medical Readiness

Objective 1: Establish and Operationalize a Health Care Coalition (HCC)

*Activity 1. Define Health Care Coalition Boundaries*

Although U.S. territories, freely associated states, and isolated frontier hospitals have limited health care infrastructure, face unique barriers, and do not encounter competitive health care organizations, they **should** conduct a review of health care utilization patterns and geographic gaps in coverage to address this FOA requirement.

In FY 2019/budget period 1, U.S. territories and freely associated states applications **must** describe their geography including all health care organizations within their jurisdiction. In addition, they **must** describe how the HCC, including the hospital, is connected to their jurisdiction's ESF-8 medical surge structure (or to government public health and medical leadership) and describe where the governmental EOC is located and the person(s) responsible to staff positions at the EOC.

*Activity 2: Identify Health Care Coalition Members*

Territories and freely associated states must ensure core HCC membership, and the funded

HCC **must** include at least the following:

- Acute care hospitals
- Public health agency
- Emergency management organization
- EMS

U.S. territories and freely associated states applications **must** describe all health care partners in detail including those connected to small islands or other land masses, atolls, and any clinics/dispensaries, dialysis centers, nursing homes, etc.

U.S. territories and freely associated states applications **must** describe the structure and functions of their public health agency, emergency management organization, and EMS partners.

*Activity 3: Establish Health Care Coalition Governance*

The U.S. territories and freely-associated states' jurisdiction's HCCs **must** meet the following requirement related to HCC governance: understanding that each jurisdiction's HCC may not have bylaws or memoranda of understanding since operations are conducted through government hospital structures, the governance roles for any hospital, clinic or dispensary, nursing home, and dialysis center should still be defined.

Objective 2: Identify Risks and Needs

*Activity 1: Assess Hazard Vulnerability and Risks*

U.S. territories, freely associated states, and isolated frontier hospitals **must** complete an annual HVA in accordance with FOA requirements and defined general principles to identify and plan for risks in collaboration with the recipient.

U.S. territories and freely associated states **must** meet JRA requirements and all timelines included in the FOA, including support of the comprehensive jurisdictional THIRA administered by DHS FEMA, if applicable.

THIRA is applicable if the jurisdiction receives DHS grants and has the THIRA requirement (applies to AS, CNMI, and USVI).

*Activity 2: Assess Regional Health Care Resources*

In order to understand the existing health care resources and services challenges, HCCs in U.S. territories and freely associated states must complete a resource assessment in accordance with FOA requirements, to identify health care resources and services that could be coordinated and shared. Isolated frontier hospitals should conduct their assessment as a comprehensive hospital-based inventory.

*Activity 4: Assess Community Planning for Children, Pregnant Women, Seniors, Individuals with Access and Functional Needs, People with Disabilities, and Others with Unique Needs*

HPP recipients in U.S. territories, and freely associated states **must** obtain de-identified data from the HHS emPOWER map at least every six months to identify populations with unique health care needs and those at-risk populations by geographic area in accordance with FOA requirements.

The emPOWER requirement applies only to AS, CNMI, and USVI.

Some jurisdictions are not included in the ATSDR's Social Vulnerability Index referenced in the FOA; therefore, the requirement does not apply.

The jurisdictions of FSM, RMI, and PW not utilizing "emergency support function" terminology, **should** connect with those government entities representing public health, medical, mass care, emergency assistance, housing, human services as appropriate when addressing the FOA requirements.

U.S. territories and freely associated states HCCs **must** meet all additional planning requirements for populations at risk including, supporting public health with data to assist at-risk population planning, among other requirements listed in the FOA.

Objective 3: Develop a Health Care Coalition Preparedness Plan

*Activity 1: Develop a Health Care Coalition Preparedness Plan*

Each U.S. territory and freely associated state jurisdiction HCC **must** update and maintain a preparedness plan and submit according to FOA requirements.

Jurisdiction HCC plans **should** also describe any preparedness planning done between U.S. territories and freely associated states and other agencies, including arrangements with the USG, USAID, DOI, etc.

Objective 5: Ensure Preparedness is Sustainable

*Activity 1. Promote the Value of Health Care and Medical Readiness*

U.S. territories and freely associated states HCCs **should** communicate the direct and indirect benefits of HCC membership to health care executives to advance their engagement in preparedness and response and to contribute to their understanding of other day-to-day benefits HCC membership offers.

*Activity 2. Engage Health Care Executives*

Health care executives can promote coordination and buy-in across all the health care facility and organization types, clinical departments, and non-clinical support services. At a minimum, jurisdiction HCCs **must** engage its members' health care executives in debriefs ("hot washes") related to exercises, planned events, and real-world events, to meet FOA requirements.

*Activity 3: Engage Clinicians*

Similar efforts as those described in the FOA **should** be made by the jurisdiction HCCs to engage

clinicians and community leaders.

*Activity 5: Promote Sustainability of Health Care Coalitions*

Understanding the financial sustainability challenges faced by the U.S. territories and freely associated states' jurisdictions, each **should** describe in their FY 2019 application, their strategies for promoting HCC value to all members.

# Capability 2: Health Care and Medical Response Coordination

Objective 1: Develop and Coordinate Health Care Organization and HCC Response Plans

*Activity 2: Develop a Health Care Coalition Response Plan*

U.S. territories and freely associated states **must** update and maintain a current all-hazards public health and medical response plan, **must** provide an opportunity for HCC members to review and provide updates, and **must** allow for public comment in accordance with FOA requirements. Jurisdictions **must** submit this all-hazards emergency preparedness and response plan to ASPR when requested and make it available during site visits.

Recipients **must** describe in their all-hazards public health emergency preparedness and response plans how they will use EMAC (if the jurisdiction has an EMAC agreement) or other mutual aid agreements that may exist in accordance with the FOA requirement.

It is understood FSM, RMI, and PW do not utilize EMAC.

U.S. territories, freely associated states, and isolated frontier hospitals **must** also include descriptions of any mutual aid agreements for public health and medical mutual aid to support coordinated activities and to share resources, facilities, services, and other potential support required when responding to public health emergencies.

The U.S. territories and freely associated states' jurisdiction HCC response plan **must** address required elements according to the FOA, understanding items such as locations for multiagency coordination, provision of specialty care, and other elements may be minimal or structured uniquely.

Integration and collaboration with the government public health and medical leadership structure satisfies ESF-8 connectivity (e.g., it is understood FSM, RMI, and PW do not recognize emergency support functions).

Training, drills, and exercises help identify and assess how well a health care delivery system or region is prepared to respond to an emergency. These activities also develop the necessary knowledge, skills, and abilities of an HCC member's workforce.

Jurisdictions **must** update their MYTEP to reflect all planned and confirmed HCC-based training and exercises, and **must** include it with their annual application during the five-year project period, understanding the jurisdictions challenges with securing training in remote locations, status of existing occupational health and infection control programs, and other factors.

Objective 2: Utilize Information Sharing Processes and Platforms

*Activity 1: Develop Information Sharing Procedures*

To establish a common operating picture that facilitates coordinated infectious disease information sharing among HCC members and relevant stakeholders, U.S. territories and freely associated states and their HCCs **should** work to establish a common operating picture that facilitates information sharing among government entities, health care, public health and other disciplines according to FOA

requirements.

Effective response coordination relies on information sharing to establish a common operating picture. Information sharing is the ability to share real-time information related to the emergency, the current-state of the health care delivery system and situational awareness across the various response organizations and levels of government.

Information sharing allows for the tracking of resource availability and needs and also allows HCC members, other stakeholders, and the jurisdiction's ESF-8 lead agency (or similar government structure) to provide coordinated, accurate, and timely information to health care providers and the public.

U.S. territories, freely associated states, and isolated frontier hospitals **must** provide situational awareness data, including data on bed availability, to ASPR during emergency response operations and at other times, as requested, and agree to participate in current and future federal health care situational awareness initiatives for the duration of the five-year project period. Jurisdictions **must** ensure that each HCC is able to access and collect timely, relevant, and actionable information about their members during emergencies.

Jurisdiction information sharing procedures **must** be documented in each HCC's response plan. When documenting information sharing procedures in response plans, jurisdiction HCCs **should** follow the definition and description outline provided in the FOA requirements.

The recipient **must** ensure their health care facilities are engaged when an emergency with the potential to impact the public's health occurs within their boundaries. The HCC and its members must, at a minimum, define and integrate into their response plans, procedures for sharing EEIs. This includes but is not limited to the current operational status of facilities, elements of electronic health records, and resource needs and availability.

ASPR will provide coordinated pre-event, post-event, and special event-specific EEIs required for integration and submission by recipients and sub-recipients by the end of the first quarter of FY 2019/budget period 1.

U.S. territories and freely associated states HCCs **must** meet all timelines outlined in the FOA for completing CAT requirements.

*Activity 3: Utilize Communications Systems and Platforms*

HPP recipients **must** identify reliable, resilient, interoperable, and redundant information and communication systems and platforms, including those for bed availability and patient tracking, and provide access to HCC members and other stakeholders.

U.S. territories, freely associated states, and isolated frontier hospitals, in coordination **should** consider the factors described in the FOA when developing processes and procedures to rapidly acquire and share clinical knowledge between health care providers and organizations, and developing the ability to rapidly alert and notify their employees, patients, and visitors and others on emergency situations.

*Activity 4: Communicate with the Public During an Emergency*

Appropriate communication with the public is important during a response to an emergency that impacts the public's health. Accordingly, health care facilities, in collaboration with HPP recipients, should agree upon and plan for the type of information that will be disseminated (by either the HCC or individual members) to the public during an emergency. This FOA requirement also applies to U.S. territories and freely associated states.

By the end of the five year project period, health care facilities must work collaboratively with all partners to provide PIO training to designated individual(s) and connect with their community's JIS to ensure information is accurate, consistent, linguistically and culturally appropriate, and disseminated to the

community  using one voice during an emergency according to FOA requirements.

## Capability 3: Continuity of Health Care Service Delivery

Objective 2: Plan for Continuity of Operations

### *Activity 2: Develop a Health Care Coalition Continuity of Operations Plan*

Each of the U.S. territories, freely associated states, and isolated health care facilities funded by the recipient must develop a COOP plan that is informed by its members' COOP plans and submit the plan to ASPR. HCC COOP plans may be an annex to the HCC's response plan or may take another form.

Jurisdictions must develop COOP plans to include the minimum FOA requirements, understanding these will have a  hospital focus, resource allocation may be limited, and other strategies will be unique to the jurisdiction.

Objective 3: Maintain Access to Non-Personnel Resources During an Emergency

### *Activity 1: Assess Supply Chain Integrity*

To ensure the ongoing delivery of patient care services following an emergency, critical equipment and supplies **must** be  made available for all populations. U.S. territories, freely associated states, and isolated frontier hospitals **must** conduct a supply chain integrity assessment to evaluate equipment and supply needs that will be in demand  during emergencies and develop strategies to address potential shortfalls. HPP recipients **must** provide  documentation of the assessment and corresponding mitigation strategies to ASPR.

Jurisdictions must address this FOA requirement for the five-year project period understanding their unique geographic  location, limited manufacturer and distributer access, and other constraints.

### *Activity 2: Assess and Address Equipment, Supply, and Pharmaceutical Requirements*

Any jurisdiction purchasing pharmaceuticals and/or medical materiel with HPP funds **must** consider strategies for their  acquisition, storage, rotation, use, and disposal according to FOA requirements. HPP recipients and HCCs **must**  document such strategies and provide documentation to ASPR.

Objective 5: Protect Responder Safety and Health

### *Activity 2: Train and Exercise to Promote Responder Safety and Health*

U.S. territories and freely associated states HCCs and their members **must** equip, train, and provide resources necessary  to protect responders, employees, and their families from hazards during response and recovery operations according  to FOA requirements. PPE, MCMs, workplace violence  training, psychological first aid training, and other interventions specific to an emergency are all necessary to protect  health care workers from illness or injury and **should** be readily available to the health care workforce.

Objective 6: Plan for Healthcare Evacuation and Relocation

### *Activity 1: Develop and Implement Evacuation and Relocation Plans*

The recipient, each HCC, and members **must** ensure all participating health care organizations, public health  agencies, and emergency management organizations are included in evacuation, transportation, and relocation planning  and execution during exercises and real world events.

Understanding challenges faced by U.S. territories, freely associated states, and isolated frontier hospitals

related to hospital evacuation, transportation, and relocation planning (AS, CNMI, FSM, PW, RMI, and USVI) will develop a surge scenario and exercise it utilizing the HST within hospitals, and include other partners (e.g., emergency management agencies, public health, EMS, etc.), as described in their response plans.

Objective 7: Coordinate Health Care Delivery System Recovery

*Activity 1: Plan for Health Care Delivery System Recovery*

U.S. territories and freely associated states must develop a health care system recovery plan and submit it to ASPR. Recovery processes may be integrated into recipients' existing plans, such as an annex to their emergency operations plan, or developed as a separate standalone plan. Each recipient should review their recovery plan after exercises and major incidents to update the following:

- Coordinated goals and strategic priorities for the continued delivery of essential health care services, including behavioral health services.

- HCC integration with the recovery lead agency for health and human services to advocate for the needs of health care, ensure information sharing, and manage resource availability within and between disciplines and coalition stakeholders.

- Prioritization of critical infrastructure dependencies necessary for the recovery of health service delivery in the following sectors: communications, emergency services, energy, food and agriculture, information technology, transportation systems, and water and wastewater systems.

- Impact assessment process including the collection of information, issues related to current operational trends and themes, and the process for relaying requests for assistance based on emerging or persistent needs.

- Stakeholder process to connect with recovery assistance programs including support with initial disaster cost estimation and assistance with state and federal disaster recovery funding application (if available).

It is understood the jurisdictions of FSM, RMI, and PW do not recognize the National Disaster Recovery Framework.

**Capability 4: Medical Surge**

Objective 1: Plan for a Medical Surge

*Activity 1: Incorporate Medical Surge Planning into a Health Care Organization Emergency Operations Plan*

U.S. territories, freely associated states, and isolated frontier hospitals **must** plan and respond to address emergency department and inpatient surge with the goal of ensuring IBA throughout the project period. The HST exercise will assist with addressing this medical surge component.

*Activity 3: Incorporate Medical Surge into a Health Care Coalition Response Plan*

Crisis Care Strategies: U.S. territories, freely associated states, and isolated frontier hospitals that coordinate during a medical surge response are more likely to effectively manage the emergency without state or federal assets or employing crisis care strategies. However, it is not possible to plan for all worst-case scenarios, and there may be times when the health care delivery system is stressed beyond its maximum surge capacity. During those scenarios, crisis care strategies may be employed and planned

for well in advance. Planning  for medical surge should follow the [medical surge capacity and capability (MSCC)](#) tiered approach, where successive  levels of assistance are activated as the emergency evolves.

HPP recipients **must** submit a new or updated Crisis Standards of Care CONOPS Plan by the end of FY 2020 that integrates the following elements as applicable:

- Ethical considerations and the state subject matter experts for consultation and engagement during emergencies

- Guidance for EMS and health care providers on recommended crisis care strategies

- Community and provider engagement, education, and communication activities (completed and planned)

- Indicators and triggers for state activation and the actions the state will take to support prolonged crisis care conditions that cannot be rapidly addressed through standard mutual aid or other mechanisms

- Operational framework for state level information management and policy development including real-time engagement of subject matter experts for technical support with allocation decisions and the coordination and decision processes for the allocation of scarce resources (e.g., pharmaceuticals or PPE) to the health and medical sector.

- Legal and regulatory state actions to be taken (as well as proposed changes to regulations/statute) that can support health care strategies during catastrophic/crisis care conditions, to include:

  1. State declarations and their powers

  2. Credentialing and licensure support for intra-state and inter-state assistance

  3. Provider protection from liability during disasters

  4. Support for alternate systems of care practices both in health care facilities and alternate environments

  5. Relief from specific regulations that may impede appropriate billing and collection for services rendered under crisis conditions

  6. State agency support for crisis care (e.g., EMS regulatory agency relief, hospital licensure requirements, state fire marshal)

Specialty Surge: HCCs **must** develop complementary coalition-level (or facility-level) annexes to their base medical surge/trauma mass casualty response plan(s) to manage a large number of casualties with specific needs. Recipients should incorporate the annexes into their jurisdiction's plan for awareness and to support coordination of state resources. In addition to the usual information management and resource coordination functions, each Specialty Surge annex framework should be similarly formatted and emphasize the following core elements:

- Indicators/triggers and alerting/notifications of a specialty event

- Initial coordination mechanism and information gathering to determine impact and specialty needs

- Documentation of available local, state, and interstate resources that can support the specialty response and key resource gaps that may require external support (including inpatient and outpatient resources)

- Access to subject matter experts – local, regional, and national

- Prioritization method for specialty patient transfers (e.g., which patients are most suited for transfer to a specialty facility)

- Relevant baseline or just-in-time training to support specialty care

- Evaluation and exercise plan for the specialty function

Pediatric – in addition to the above consider:

- Local risks for pediatric-specific mass casualty events (e.g. schools, transportation accidents)

- Age-appropriate medical supplies

- Mental health and age-appropriate support resources

- Pediatric/NICU evacuation resources and coalition plan

- Coordination mechanisms with dedicated children's hospital(s)

Burn – in addition to the above consider:

- Local risks for mass burn events (e.g., pipelines, industrial, terrorist, transportation accidents)

- Burn-specific medical supplies

- Coordination mechanisms with ABA centers/region

- Incorporation of critical care air/ground assets suitable for burn patient transfer

Infectious disease – in addition to the above consider:

- Expanding existing Ebola CONOPs to enhance preparedness and response for all novel/high consequence infectious diseases

- Developing recipient and coalition-level anthrax response plans

- Developing recipient and coalition-level pandemic response plan

- Including HAI professionals at the health care facility and jurisdictional levels in planning, training, and exercises/drills

- Developing a continuous screening process for acute care patients and integrate information with EHRs where possible in HCC member facilities and organizations

- Coordinating visitor policies for infectious disease emergencies at member facilities to ensure uniformity

- Coordinating MCM distribution and use by health care facilities for use in prophylaxis and acute patient treatment

- Developing and exercising plans to coordinate patient distribution for highly pathogenic respiratory viruses and other highly transmissible infections, including complicated and critically ill infectious disease patients, when tertiary care facilities or designated facilities are not available

Radiation – in addition to the above consider:

- Local risks for radiation mass casualty events (e.g., power plant, industrial/research, RDD, nuclear detonation)

- Detection and dosimetry equipment for EMS/hospitals

- Decontamination protocols

- On-scene triage/screening, assembly center, and community reception center activities

- Treatment protocols/information

- Coordination mechanisms with hematology/oncology centers and RITN

Chemical – in addition to the above consider:

- Determine risks for community chemical events (e.g., industrial, terrorist, transportation-related)

- Decontamination assets and throughput (pre-hospital and hospital) including capacity for dry decontamination

- Determine EMS and hospital PPE for HAZMAT events

- Review and update Chempack (and/or other chemical countermeasure) mobilization and distribution plan

- Coordinate training for their members on the provision of wet and dry decontamination and screening to differentiate exposed from unexposed patients

- Ensure involvement and coordination with regional HAZMAT resources (where available) including EMS, fire service, health care organizations, and public health agencies (for public messaging)

- Develop plans for a community reception center with public health partners

Objective 2: Respond to a Medical Surge

*Activity 1: Implement Emergency Department and Inpatient Medical Surge Response*

Each U.S. territory, freely associated state, and isolated frontier hospital must plan and exercise based on the following FOA requirements:

The jurisdictions (AS, CNMI, FSM, PW, RMI, and USVI) will develop a surge scenario and exercise it utilizing the HST within hospitals, and include other partners (e.g., emergency management agency, public health, EMS, etc.). Addressing gaps from risk assessments should be considered, as well as an evacuation component at least once during the project period. Facilities are encouraged to partner with government entities such as the Federal Aviation Administration, U.S. DoD, or DOI, as well as other nearby the U.S. territories or freely associated states should additional coordination support their exercise.

- MYTEP submission (due at time of application)

- AAR/IP submission (redacted for each hospital surge test) required and sent to ASPR within 120 days of exercise completion.

- Opportunities for improvement identified in the AAR/IP should inform MYTEP revisions, be included within future exercises, and inform future work plans.

U.S. territories, freely associated states, and isolated hospitals **must** also report on performance measures resulting from the hospital surge test.

In lieu of the hospital surge test:

U.S. territories and freely-associated states, may conduct a joint exercise with other island and/or territorial or freely associated jurisdictions (functional or full-scale exercise) once during the project period to test progress toward achieving the capabilities outlined in the [2017-2022 Health Care Preparedness and Response Capabilities](). The elements of legal considerations, medical support, patient evacuation & tracking, incident command support, shelter health support, information sharing, and financial reimbursement should be considered. The exercise plan shall be reviewed by the FPO and approved in the annual work plan.

*Activity 3: Develop an Alternate Care System*

Accordingly, HPP recipients and health care facilities should plan for the development of alternate care systems, in collaboration with  state and local public health agencies and emergency management organizations.

Jurisdictions with capability to develop or improve their alternate care systems should use the additional factors and  other FOA guidance for development in this area.

*Activity 9: Enhance Infectious Disease Preparedness and Surge Response*

HPP recipients, as well as HCCs and their members all have roles in planning for and responding to infectious  disease outbreaks that stress either the capacity and/or the capability of the public health and/or health care delivery  systems.

U.S. territories, freely associated states, isolated frontier hospitals, and their HCCs **must** follow all required FOA guidelines to: 1. Establish a  common operating picture, 2. Establish key indicators, 3. Collaborate to provide real-time information, 4. Coordinate  public messaging, 5. Ensure infectious disease response planning, 5. Coordinate management of the deceased, and 6.  Identify, leverage, and share leading practices.

It is understood the jurisdiction approach to outlined recommendations and requirements in the FOA will differ due to  their remote location, infrastructure challenges, and other factors.

## Appendix D: FY2019 HPP Performance Measures

| FY2019 HPP Performance Measures | Recipient | HCC | Territory, FAS, or Isolated Frontier Hospital |
|---|---|---|---|
| PM1: Percent of funding each HCC receives from the recipient, other federal sources, and non-federal sources. | X | X | X |
| PM2: Number of calendar days from start of fiscal year for recipients to execute subawards with each HCC. | X | | X |
| PM3: Number of calendar days from the start of fiscal year for recipients to provide a detailed spend plan, including all budget line items, to all HCCs within their jurisdiction and any interested health care entity. | X | | X |
| PM4: Membership representation rate of HCC core (acute care hospitals, EMS, emergency management, public health) and additional member organizations by member type. | X | X | X |
| PM5: Percent of HCCs that have a complete and approved response plan annex addressing the required **annual Specialty Surge** requirement. | | X | X |
| PM6: Percent of HCCs that have a complete and approved response plan. | | X | X |
| PM7, Part A: Percent of recipients that obtain de-identified data from emPOWER at least once every six months to identify numbers of individuals with electricity-dependent medical and assistive equipment for planning purposes. | X | | Applies only to AS, CNMI, and USVI |

| FY2019 HPP Performance Measures | Recipient | HCC | Territory, FAS, or Isolated Frontier Hospital |
|---|---|---|---|
| PM7, Part B: Percent of HCCs that obtain de-identified data from emPOWER at least once every six months to identify numbers of individuals with electricity-dependent medical and assistive equipment for planning purposes. | | X | Applies only to AS, CNMI, and USVI |
| PM8: Percent of recipients that have provided an opportunity for each HCC to review and provide input to the recipient's ESF-8 preparedness and response plan. | X | | X |
| PM9: Percent of HCCs engaged in their recipient's jurisdictional risk assessment. | | X | X |
| PM10: Percent of HCCs where areas for improvement have been identified from HCC and member organizations' own exercises or real-world events and the HCCs' preparedness and response plans have been revised to reflect improvements. | | X | X |
| PM11: Percent of recipients with a complete, jurisdiction-wide protocol that delineates (a) the appropriate allocation of scarce resources during crises and (b) local and regional crisis standards of care planning and implementation efforts. | X | X | X |
| PM12: Percent of HCCs that have drilled their primary communications plan and system/platform and one redundant communications system/platform (not connected to the commercial power grid) at least once every six months. | | X | X |
| PM13: Percent of HCC member organizations that responded during each redundant communications drill by system/platform type used. | | X | X |

| FY2019 HPP Performance Measures | Recipient | HCC | Territory, FAS, or Isolated Frontier Hospital |
|---|---|---|---|
| PM14: Percent of HCC core member organizations participating in Phase 1: Table Top Exercise with Functional Elements and Facilitated Discussion of the Coalition Surge Test. | | X | |
| PM15: Percent of HCC core member organizations' executives participating in Phase 2: After Action Review of the Coalition Surge Test. | | X | |
| PM16: Percent of patients at the evacuating facilities that are identified as able to be: a) discharged safely to home or b) evacuated to receiving facilities during Phase 1: Table Top Exercise with Functional Elements and Facilitated Discussion of the Coalition Surge Test. | | X | |
| PM17: Time [in minutes] for evacuating facilities in the HCC to report the total number of evacuating patients. | | X | |
| PM18: Percent of evacuating patients with an appropriate bed identified at a receiving health care facility within 90 minutes. | | X | |
| PM19: Time [in minutes] for receiving facilities in the HCC to report the total number of beds available to receive patients. | | X | |
| PM20: Percent of evacuating patients with acceptance for transfer to another facility that have an **appropriate** mode of transport identified in 90 minutes. | | X | |
| PM21: Time [in minutes] for the HCCs to identify an appropriate mode of transport for **all** evacuating patients. | | X | |

| FY2019 HPP Performance Measures | Recipient | HCC | Territory, FAS, or Isolated Frontier Hospital |
|---|---|---|---|
| PM22: Percent of hospitals with an Emergency Department recognized through a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies. | X | X | X |
| PM HPP-PHEP J.2: HPP and PHEP recipients should coordinate the identification, recruitment, registration, training, and engagement of volunteers to support the jurisdiction's response to incidents.<br><br>Recipients should ensure the use of volunteers to support acute care medical surge response is incorporated into training, drills, and exercises throughout the five-year project period. | X | X | X |
| PM23: Percent of HCC core member organizations participating in the Command Center Table Top and Emergency Department Table Top during the hospital surge test. | | | X |
| PM24: Percent of HCC core member organizations with at least one executive participating in the After Action Review of the hospital surge test. | | | X |
| PM25: Percentage of ICU beds made available during the hospital surge test. | | | X |
| PM26: Percentage of non-ICU beds made available during the hospital surge test. | | | X |
| PM27: Percentage of emergency department beds made available during the hospital surge test. | | | X |

| FY2019 HPP Performance Measures | Recipient | HCC | Territory, FAS, or Isolated Frontier Hospital |
|---|---|---|---|
| PM28: Percentage of patients with a bed identified in the emergency department during the hospital surge test. | | | X |

**Attachment 1: Instructions for Completing Required Forms (SF-424, Budget (SF-424A), Budget Narrative/Justification)**

This section provides step-by-step instructions for completing the four (4) standard federal forms required as part of your grant application, including special instructions for completing Standard Budget Forms 424 and 424A. SFs 424 and 424A are used for a wide variety of federal grant programs, and federal agencies have the discretion to require some or all of the information on these forms. ASPR does not require all the information on these SFs. Accordingly, please use the instructions below to complete these forms in lieu of the standard instructions attached to SFs 424 and 424A.

a. SF-424

1. **Type of Submission:** (Required): Select one type of submission in accordance with agency instructions.

   - Application

2. **Type of Application**: (Required) Select one type of application in accordance with agency instructions.

   - New

3. **Date Received:** Leave this field blank.

4. **Applicant Identifier**: Leave this field blank

5. **5a. Federal Entity Identifier**: Leave this field blank

   **5b. Federal Award Identifier**: for new applications, leave blank.

6. **Date Received by State:** Leave this field blank.

7. **State Application Identifier:** Leave this field blank.

8. **Applicant Information**: Enter the following in accordance with agency instructions:

   a. **Legal Name** (Required): Enter the name that the organization has registered with the Central Contractor Registry (CCR). Information on registering with CCR may be obtained by visiting the Grants.gov webpage.

   b. **Employer/Taxpayer Number (EIN/TIN)**(Required): Enter the Employer or Taxpayer Identification Number (EIN or TIN) as assigned by the Internal Revenue Service.

   c. **Organizational DUNS** (Required): Enter the organization's DUNS or DUNS+4 number received from Dun and Bradstreet. Information on obtaining a DUNS number may be obtained by visiting the Grants.gov webpage.

   d. **Address** (Required): Enter the complete address including the county.

   e. **Organizational Unit:** Enter the name of the primary organizational unit (and department or division, if applicable**)** that will undertake the project.

   f. **Name and contact information of person to be contacted on matters involving this application**: Enter the name (first and last name required), organizational affiliation (if affiliated with an organization other than the applicant organization), telephone number (Required), fax number, and e-mail address (required) of the person to contact on matters related to this application.

9. **Type of Applicant** (Required): Select the applicant organization "type" from the drop down list.

10. **Name of Federal Agency** (Required): Enter U.S. Assistant Secretary for Preparedness and Response.

11. **Catalog of Federal Domestic Assistance Number/Title:** The CFDA number can be found on page one of the FOA.

12. **Funding Opportunity Number/Title** (Required): The Funding Opportunity Number and title of the opportunity can be found on page one of the FOA.

13. **Competition Identification Number/Title:** Leave this field blank.

14. **Areas Affected By Project:** List the largest political entity affected (cities, counties, state, etc.).

15. **Descriptive Title of Applicant's Project** (Required): Enter a brief descriptive title of the project.

16. **Congressional Districts Of** (Required): **16a.** Enter the applicant's Congressional District, and **16b.** Enter all district(s) affected by the program or project. Enter in the following format: 2 characters state abbreviation – 3 characters district number, CA-005 for California 5th district. If all congressional districts in a state are affected, enter "all" for the district number, (e.g. MD-all for all congressional districts in Maryland). If nationwide enter US-all.

17. **Proposed Project Start and End Dates** (Required): Enter the proposed start date and final end date of the project. Therefore, if you are applying for a multi-year grant, such as a 3-year grant project, the final project end date will be 3 years after the proposed start date. The Grants Office can alter the start and end date at their discretion.

18. **Estimated Funding** (Required): Enter the amount requested or to be contributed during the first funding/budget period by each contributor. Value of in-kind contributions should be included on appropriate lines, as applicable.

19. Is Application Subject to Review by State Under Executive Order 12372 Process? Check appropriate box.

20. **Is the Applicant Delinquent on any Federal Debt?** (Required): This question applies to the applicant organization, not the person who signs as the authorized representative. If yes, include an explanation on the continuation sheet.

21. **Authorized Representative** (Required): To be signed and dated by the authorized representative of the applicant organization. Enter the name (first and last name required) title (required), telephone number (required), fax number, and e-mail address (required) of the person authorized to sign for the applicant. A copy of the governing body's authorization for you to sign this application as the official representative must be on file in the applicant's office. (Certain federal agencies may require that this authorization be submitted as part of the application.)

b. SF-424A

NOTE: SF-424A is designed to accommodate applications for multiple grant programs; thus, for purposes of this ASPR program, many of the budget item columns and rows are not applicable. You should only consider and respond to the budget items for which guidance is provided below. Unless otherwise indicated, the SF-424A should reflect a one-year budget.

**Section A – Budget Summary**

**Line 5**: Leave columns (c) and (d) blank. Enter TOTAL federal costs in column (e) and total non-federal costs (including third party in-kind contributions and any program income to be used as part of the recipient match) in column (f). Enter the sum of columns (e) and (f) in column (g).

## Section B – Budget Categories

Column 3: Enter the breakdown of how you plan to use the federal funds being requested by object class category (see instructions for each object class category below).

Column 4: Enter the breakdown of how you plan to use the non-federal share by object class category. [DOES NOT APPLY TO THIS FOA.]

Column 5: Enter the total funds required for the project (sum of Columns 3 and 4) by object class category.

### Separate Budget Narrative/Justification Requirement

**Applicants requesting funding for multi-year grant programs are REQUIRED to provide a combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding. A separate Budget Narrative/Justification is also REQUIRED for each potential year of grant funding requested.**

For your use in developing and presenting your Budget Narrative/Justification, a sample format with examples and a blank sample template have been included in these Attachments. In your Budget Narrative/Justification, you should include a breakdown of the budgetary costs for all of the object class categories noted in Section B, across three columns: federal; non-federal cash; and non-federal in-kind. Cost breakdowns, or justifications, are required for any cost of $1,000 or for the thresholds as established in the examples. The Budget Narratives/Justifications should fully explain and justify the costs in each of the major budget items for each of the object class categories, as described below. Non-federal cash as well as, sub-contractor or sub-recipient (third party) in-kind contributions designated as match must be clearly identified and explained in the Budget Narrative/Justification The full Budget Narrative/Justification should be included in the application immediately following the SF-424 forms.

**Line 6a – Personnel**: Enter total costs of salaries and wages of applicant/recipient staff. Do not include the costs of consultants, which should be included under 6h - Other.

**In the Justification**: Identify the project director, if known. Specify the key staff, their titles, and time commitments in the budget justification.

**Line 6b – Fringe Benefits**: Enter the total costs of fringe benefits unless treated as part of an approved indirect cost rate.

**In the Justification**: If the total fringe benefit rate exceeds 35% of personnel costs, provide a break-down of amounts and percentages that comprise fringe benefit costs, such as health insurance, FICA, retirement, etc. A percentage of 35% or less does not require a break down but you must show the percentage charged for each full/part time employee.

**Line 6c – Travel**: Enter total costs of all travel (local and non-local) for staff on the project. NEW: Local travel is considered under this cost item not under the "Other" cost category.

Local transportation (all travel which does not require per diem is considered local travel). Do not enter costs for consultant's travel - this should be included in line 6h.

**In the Justification**: Include the total number of trips, number of travelers, destinations, purpose (attend conference), length of stay, subsistence allowances (per diem), and transportation costs (including mileage rates).

**Line 6d - Equipment**: Enter the total costs of all equipment to be acquired by the project. For all recipients, "equipment" is non-expendable tangible personal property having a useful life of more than

one year and an acquisition cost of $5,000 or more *per unit*. If the item does not meet the $5,000 threshold, include it in your budget under Supplies, line 6e.

**In the Justification**: Equipment to be purchased with federal funds must be justified as necessary for the conduct of the project. The equipment must be used for project-related functions. Further, the purchase of specific items of equipment should not be included in the submitted budget if those items of equipment, or a reasonable facsimile, are otherwise available to the applicant or its sub-recipients.

**Line 6e: Supplies –** Enter the total costs of all tangible expendable personal property (supplies) other than those included on line 6d.

**In the Justification**: For any grant award that has supply costs in excess of 5% of total direct costs (federal or non-federal), you must provide a detailed breakdown of the supply items ( 6% of $100,000 = $6,000 – breakdown of supplies needed). If the 5% is applied against $1 million total direct costs (5% x $1,000,000 = $50,000) a detailed breakdown of supplies is not needed. Please note: any supply costs of $5,000 or less regardless of total direct costs does not require a detailed budget breakdown (5% x $100,000 = $5,000 – no breakdown needed).

**Line 6f – Contractual**: Regardless of the dollar value of any contract, you must follow your established policies and procedures for procurements and meet the minimum standards established in the Code of Federal Regulations (CFRs) mentioned below. Enter the total costs of all contracts, including procurement contracts (except those which belong on other lines such as equipment, supplies, etc.). Note: The 33 percent provision has been removed and line item budget detail is not required as long as you meet the established procurement standards.  Also include any contracts with organizations for the provision of TA. Do not include payments to individuals on this line.

**In the Justification**: Provide the following three items – 1) a list of contractors indicating the name of the organization; 2) the purpose of the contract; and 3) the estimated dollar amount. If the name of the contractor and estimated costs are not available or have not been negotiated, indicate when this information will be available. The federal government reserves the right to request the final executed contracts at any time. If an individual contractual item is over the small purchase threshold, currently set at $100K in the CFR, you must certify that your procurement standards are in accordance with the policies and procedures as stated in 45 CFR 75.327 General Procurement Standards, in lieu of providing separate detailed budgets. This certification should be referenced in the justification and attached to the budget narrative.

**Line 6g – Construction**: While construction is not an allowable cost for this program, minor A&R is permitted.

**Line 6h – Other**: Enter the total of all other costs. Such costs, where applicable, may include, but are not limited to: insurance, medical and dental costs (e.g., for project volunteers this is different from personnel fringe benefits), non-contractual fees and travel paid directly to *individual* consultants, postage, space and equipment rentals/lease, printing and publication, computer use, training and staff development costs (e.g., registration fees). If a cost does not clearly fit under another category, and it qualifies as an allowable cost, then it belongs in this section.

**In the Justification**: Provide a reasonable explanation for items in this category. For example, individual consultants explain the nature of services provided and the relation to activities in the Work Plan or indicate where it is described in the Work Plan. Describe the types of activities for staff development costs.

**Line 6i – Total Direct Charges**: Show the totals of Lines 6a through 6h.

**Line 6j – Indirect Charges**: Enter the total amount of indirect charges (costs), if any. If no indirect costs

are requested, enter "none." Indirect charges may be requested if: (1) the applicant has a current indirect cost rate agreement approved by the HHS or another federal agency; or (2) the applicant is a state or local government agency. **State governments should enter the amount of indirect costs determined in accordance with HHS requirements.** An applicant that will charge indirect costs to the grant must enclose a copy of the current rate agreement. Indirect Costs can only be claimed on federal funds, more specifically, they are to only be claimed on the federal share of your direct costs. Any unused portion of the recipient's eligible Indirect Cost amount that are not claimed on the federal share of direct charges can be claimed as un-reimbursed indirect charges, and that portion can be used towards meeting the recipient match.

Non-federal entities that have never received a negotiated indirect cost rate paragraphs (c)(1)(i) and (ii) and section (D)(1)(b) of may elect to charge a de minimis rate of 10 percent of modified total direct costs (MTDC) which may be used indefinitely. As described in 45 CFR 75.403, costs must be consistently charged as either indirect or direct costs, but may not be double charged or inconsistently charged as both. If chosen, this methodology once elected must be used consistently for all Federal awards until such time as a non-federal entity chooses to negotiate for a rate, which the non-federal entity may apply to do at any time.

Non-federal entities that have a current federally negotiated indirect cost rate may apply for a one-time extension of the rates in that agreement for a period of up to four years. This extension will be subject to the review and approval of the cognizant agency for indirect costs. If an extension is granted the non-federal entity may not request a rate review until the extension period ends. At the end of the 4-year extension, the non-federal entity must re-apply to negotiate a rate. Subsequent one-time extensions (up to four years) are permitted if a renegotiation is completed between each extension request.

NOTE: If indirect costs are to be included in the application, a copy of the approved indirect cost agreement must be included with the application. Further, if any sub-contractors or sub-recipients are requesting indirect costs, copies of their indirect cost agreements must also be included with the application.

**Line 6k – Total**: Enter the total amounts of Lines 6i and 6j.

**Line 7 – Program Income**: As appropriate, include the estimated amount of income, if any, you expect to be generated from this project that you wish to designate as match (equal to the amount shown for Item 15(f) on Form 424). **Note:** Any program income indicated at the bottom of Section B and for item 15(f) on the face sheet of Form 424 will be included as part of non-federal match and will be subject to the rules for documenting completion of this pledge. If program income is expected, but is not needed to achieve matching funds, **do not** include that portion here or on Item 15(f) of the Form 424 face sheet. Any anticipated program income that will not be applied as Recipient match should be described in the Level of Effort section of the Program Narrative.

**Section C – Non-Federal Resources**

**Line 12:** Enter the amounts of non-federal resources that will be used in carrying out the proposed project, by source (applicant; state; other) and enter the total amount in Column (e). Federal match is required for this FOA (Please see Section C of this FOA – Cost Sharing and Match – for more information).

**Section D** – **Forecasted Cash Needs - Not applicable.**

**Section E** – **Budget Estimate of Federal Funds Needed for Balance of the Project**

**Line 20:** Section E is relevant for multi-year grant applications, where the project period is 24 months or

longer. This section does not apply to grant awards where the project period is less than 17 months.

**Section F – Other Budget Information**

**Line 22 - Indirect Charges:** Enter the type of indirect rate (provisional, predetermined, final or fixed) to be in effect during the funding period, the base to which the rate is applied, and the total indirect costs. Include a copy of your current Indirect Cost Rate Agreement.

**Line 23 - Remarks:** Provide any other comments deemed necessary

**c. Standard Form 424B - Assurances**

This form contains assurances required of applicants under the discretionary funds programs administered by the ASPR. Please note that a duly authorized representative of the applicant organization must certify that the organization is in compliance with these assurances.

**d. Certification Regarding Lobbying**

This form contains certifications that are required of the applicant organization regarding lobbying. Please note that a duly authorized representative of the applicant organization must attest to the applicant's compliance with these certifications.

**Proof of Non-Profit Status**

Non-profit applicants must submit proof of non-profit status. Any of the following constitutes acceptable proof of such status:

- A copy of a currently valid IRS tax exemption certificate.

- A statement from a state taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a non-profit status and that none of the net earnings accrue to any private shareholders or individuals.

- A certified copy of the organization's certificate of incorporation or similar document that clearly establishes non-profit status.

**Indirect Cost Agreement**

Applicants that have included indirect costs in their budgets must include a copy of the current indirect cost rate agreement approved by the HHS or another Federal agency. This is optional for applicants that have not included indirect costs in their budgets.

# Glossary

**Activities:** The actual events or actions that take place as a part of the program.

**Administrative and National Policy Requirements, Additional Requirements (ARs):** Administrative requirements found in 45 CFR Part 75 and other requirements mandated by statute or ASPR policy. Recipients must comply with the ARs listed in the FOA.

**Approved but Unfunded:** Approved but unfunded refers to applications recommended for approval during the objective review process; however, they were not recommended for funding by the program office and/or the grants management office.

**Award:** Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements (e.g., cooperative agreements) in the form of money, or property in lieu of money, by the federal government to an eligible applicant.

**Budget Period or Budget Year:** The duration of each individual funding period within the project period. Traditionally, budget periods are 12 months or 1 year.

**Carryover:** Unobligated federal funds remaining at the end of any budget period that, with the approval of the GMO or under an automatic authority, may be carried over to another budget period to cover allowable costs of that budget period either as an offset or additional authorization. Obligated but liquidated funds are not considered carryover.

**Catalog of Federal Domestic Assistance (CFDA):** A government-wide compendium published by the General Services Administration (available on-line in searchable format as well as in printable format as a .pdf file) that describes domestic assistance programs administered by the Federal Government.

**CFDA Number:** A unique number assigned to each program and FOA throughout its lifecycle that enables data and funding tracking and transparency.

**Competing Continuation Award:** A financial assistance mechanism that adds funds to a grant and adds one or more budget periods to the previously established project period (i.e., extends the "life" of the award).

**Continuous Quality Improvement:** A system that seeks to improve the provision of services with an emphasis on future results.

**Contracts:** An award instrument used to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the federal government.

**Cooperative Agreement:** A financial assistance award with the same kind of interagency relationship as a grant except that it provides for substantial involvement by the federal agency funding the award. Substantial involvement means that the recipient can expect federal programmatic collaboration or participation in carrying out the effort under the award.

**Cost Sharing or Matching:** Refers to program costs not borne by the federal government but by the recipients. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the recipient.

**Direct Assistance (DA):** A financial assistance mechanism, which must be specifically authorized by statute, whereby goods or services are provided to recipients in lieu of cash. DA generally involves the assignment of federal personnel or the provision of equipment or supplies, such as vaccines. DA is primarily used to support payroll and travel expenses of HHS employees assigned to state, tribal, local, and territorial (STLT) health agencies that are recipients of grants and cooperative agreements. Most legislative authorities that provide financial assistance to STLT health agencies allow for the use of DA.

**DUNS:** The Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number is a nine-digit number assigned by Dun and Bradstreet Information Services. When applying for Federal awards or cooperative agreements, all applicant organizations must obtain a DUNS number as the Universal Identifier. DUNS number assignment is free. If requested by telephone, a DUNS number will be provided immediately at no charge. If requested via the Internet, obtaining a DUNS number may take one to two days at no charge. If an organization does not know its DUNS number or needs to register for one, visit Dun & Bradstreet at http://fedgov.dnb.com/webform/displayHomePage.do.

**Evaluation (program evaluation):** The systematic collection of information about the activities, characteristics, and outcomes of programs (which may include interventions, policies, and specific projects) to make judgments about that program, improve program effectiveness, and/or inform decisions about future program development.

**Federal Funding Accountability and Transparency Act of 2006 (FFATA):** Requires that information about federal awards, including awards, contracts, loans, and other assistance and payments, be available to the public on a single website at www.USAspending.gov.

**Fiscal Year:** The year for which budget dollars are allocated annually. The federal fiscal year starts October 1 and ends September 30.

**Grant:** A legal instrument used by the federal government to transfer anything of value to a recipient for public support or stimulation authorized by statute. Financial assistance may be money or property. The definition does not include a federal procurement subject to the Federal Acquisition Regulation; TA (which provides services instead of money); or assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct payments of any kind to a person or persons. The main difference between a grant and a cooperative agreement is that in a grant there is no anticipated substantial programmatic involvement by the federal government under the award. **Grants.gov:** A "storefront" web portal for electronic data collection (forms and reports) for federal grant-making agencies at www.grants.gov.

**Grants Management Officer (GMO):** The individual designated to serve as the HHS official responsible for the business management aspects of a particular grant(s) or cooperative agreement(s). The GMO serves as the counterpart to the business officer of the recipient organization. In this capacity, the GMO is responsible for all business management matters associated with the review, negotiation, award, and administration of grants and interprets grants administration policies and provisions. The GMO works closely with the program or project officer who is responsible for the scientific, technical, and programmatic aspects of the grant.

**Grants Management Specialist (GMS):** A federal staff member who oversees the business and other non-

programmatic aspects of one or more grants and/or cooperative agreements. These activities include, but are not limited to, evaluating grant applications for administrative content and compliance with regulations and guidelines, negotiating grants, providing consultation and TA to recipients, post-award administration and closing out grants.

**Health Disparities:** Differences in health outcomes and their determinants among segments of the population as defined by social, demographic, environmental, or geographic category.

**Health Equity:** Striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.

**Health Inequities:** Systematic, unfair, and avoidable differences in health outcomes and their determinants between segments of the population, such as by socioeconomic status, demographics, or geography.

**Healthy People 2020:** National health objectives aimed at improving the health of all Americans by encouraging collaboration across sectors, guiding people toward making informed health decisions, and measuring the effects of prevention activities.

**Inclusion:** Both the meaningful involvement of a community's members in all stages of the program process and the maximum involvement of the target population that the intervention will benefit. Inclusion ensures that the views, perspectives, and needs of affected communities, care providers, and key partners are considered.

**Indirect Costs:** Costs that are incurred for common or joint objectives and not readily and specifically identifiable with a particular sponsored project, program, or activity; nevertheless, these costs are necessary to the operations of the organization. For example, the costs of operating and maintaining facilities, depreciation, and administrative salaries generally are considered indirect costs.

**Intergovernmental Review:** Executive Order 12372 governs applications subject to Intergovernmental Review of Federal Programs. This order sets up a system for state and local governmental review of proposed federal assistance applications. Contact the state single point of contact (SPOC) to alert the SPOC to prospective applications and to receive instructions on the State's process. Visit the following web address to get the current SPOC list: http://www.whitehouse.gov/omb/grants_spoc/.

**Letter of Intent (LOI):** A preliminary, non-binding indication of an organization's intent to submit an application.

**Lobbying:** Direct lobbying includes any attempt to influence legislation, appropriations, regulations, administrative actions, executive orders (legislation or other orders), or other similar deliberations at any level of government through communication that directly expresses a view on proposed or pending legislation or other orders, and which is directed to staff members or other employees of a legislative body, government officials, or employees who participate in formulating legislation or other orders. Grass roots lobbying includes efforts directed at inducing or encouraging members of the public to contact their elected representatives at the federal, state, or local levels to urge support of, or opposition to, proposed or pending legislative proposals.

**Maintenance of Effort:** A requirement contained in authorizing legislation, or applicable regulations that a recipient must agree to contribute and maintain a specified level of financial effort from its own resources or

other nongovernment sources to be eligible to receive federal grant funds. This requirement is typically given in terms of meeting a previous base-year dollar amount.

**Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA):** Document that describes a bilateral or multilateral agreement between parties expressing a convergence of will between the parties, indicating an intended common line of action. It is often used in cases where the parties either do not imply a legal commitment or cannot create a legally enforceable agreement.

**Non-Profit Organization:** Any corporation, trust, association, cooperative, or other organization that is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; is not organized for profit; and uses net proceeds to maintain, improve, or expand the operations of the organization. Non-profit organizations include institutions of higher educations, hospitals, and tribal organizations (that is, Indian entities other than federally recognized Indian tribal governments).

**Notice of Award (NoA):** The official document, signed (or the electronic equivalent of signature) by a Grants Management Officer that: (1) notifies the recipient of the award of a grant; (2) contains or references all the terms and conditions of the grant and Federal funding limits and obligations; and (3) provides the documentary basis for recording the obligation of Federal funds in the HHS accounting system.

**Objective Review:** A process that involves the thorough and consistent examination of applications based on an unbiased evaluation of scientific or technical merit or other relevant aspects of the proposal. The review is intended to provide advice to the persons responsible for making award decisions.

**Outcome:** The results of program operations or activities; the effects triggered by the program. For example, increased knowledge, changed attitudes or beliefs, reduced tobacco use, reduced morbidity and mortality.

**Performance Measurement:** The ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals, typically conducted by program or agency management. Performance measurement may address the type or level of program activities conducted (process), the direct products and services delivered by a program (outputs), or the results of those products and services (outcomes). A "program" may be any activity, project, function, or policy that has an identifiable purpose or set of objectives.

**Plain Writing Act of 2010:** Plain Writing Act of 2010, PL 111-274 requires federal agencies to communicate with the public in plain language to make information more accessible and understandable by intended users, especially people with limited health literacy skills or limited English proficiency. The Plain Writing Act is available at www.plainlanguage.gov.

**Program Strategies:** Strategies are groupings of related activities, usually expressed as general headers (e.g., Partnerships, Assessment, and Policy) or as brief statements (e.g., Form partnerships, Conduct assessments, Formulate policies).

**Program Official:** Person responsible for developing the FOA; can be either a project officer, program manager, branch chief, division leader, policy official, center leader, or similar staff member.

**Project Period Outcome:** An outcome that will occur by the end of the FOA's funding period.

**Regulation:** An official rule or order, having legal force, usually issued by an administrative agency. 131

**Social Determinants of Health:** Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

**Statute:** An act of the legislature; a particular law enacted and established by the will of the legislative department of government, expressed with the requisite formalities. In foreign or civil law any particular municipal law or usage, though resting for its authority on judicial decisions, or the practice of nations.

**Statutory Authority:** Authority provided by legal statute that establishes a federal financial assistance program or award.

**System for Award Management (SAM):** The primary vendor database for the U.S. federal government. SAM validates applicant information and electronically shares secure and encrypted data with federal agencies' finance offices to facilitate paperless payments through Electronic Funds Transfer (EFT). SAM stores organizational information, allowing www.grants.gov to verify identity and pre-fill organizational information on grant applications.

**Technical Assistance:** Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation that is provided by the funding agency.

**THIRA**: The Threat and Hazard Identification and Risk Assessment (THIRA) is a 4 step common risk assessment process that helps the whole community—including individuals, businesses, faith-based organizations, non-profit groups, schools and academia and all levels of government—understand its risks and estimate capability requirements.

**Work Plan:** The summary of project period outcomes, strategies and activities, personnel and/or partners who will complete the activities, and the timeline for completion. The work plan will outline the details of all necessary activities that will be supported through the approved budget.

**FOA-specific Glossary and Acronyms**

**Acute Care Hospital:** A hospital that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries usually for a short-term illness or condition.

**Alternate Care System:** The utilization of non-traditional settings and modalities for health care deliver.

**Emergency Support Function (ESF):** As defined in the National Response Framework, an ESF refers to a group of capabilities of federal departments and agencies to provide the support, resources, program implementation, and services that are most likely to be needed to save lives, protect property, restore essential services and critical infrastructure, and help victims return to normal following a national incident. An ESF represents the primary operational level mechanism to orchestrate activities to provide assistance to state, tribal, or local governments, or to federal departments or agencies conducting missions of primary federal responsibility.

**ESF-8 Public Health and Medical Services:** Provides the mechanism for coordinated federal assistance to supplement state, tribal, and local resources in response to an emergency.

**Fiscal Preparedness:** The process of ensuring that fiscal and administrative authorities and practices that govern funding, procurement, contracting, hiring, and legal capabilities necessary to mitigate, respond to, and recover from public health emergencies can be accelerated, modified, streamlined, and accountably managed at all levels of government.

**Health Care Coalition:** ASPR defines a health care coalition as a coordinating body that incentivizes diverse and often competitive health care organizations and other community partners with differing priorities and objectives to work together to prepare for, respond to, and recover from emergencies and other incidents that impact the public's health

**Health Care Coalition Member:** ASPR defines an HCC member as an entity within the HCC's defined boundaries that actively contributes to HCC strategic planning, identification of gaps and mitigation strategies, operational planning and response, information sharing, and resource coordination and management.

**Immediate Bed Availability:** Immediate bed availability (IBA) is defined as the ability of a hospital to provide no less than 20% bed availability of staffed beds within four hours of a disaster.

**Mission Ready Package (MRP)**: Describes specific response and recovery resource capabilities that are organized, developed, trained, and exercised prior to an emergency or disaster.

**Outcome Measure:** Also be called impact measures, outcome measures assess direct and indirect program impact over time.

**Process Measure:** Focuses on the actual operation of a program to help identify progress as well as strengths and weaknesses. Process measures help define the structural and process components of the program and can be applied to document the delivery and improvement of the program.